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OCCUPATIONAL THERAPY COMMUNITY REINTEGRATION FOR INMATES
WITH CO-OCCURRING DISORDERS

by

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A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master's of Occupational Therapy

Grand Forks, North Dakota

May 2019

Approval Page

This Scholarly Project Paper, submitted by Miranda Hosking and Kara Moore in partial fulfillment of the requirements for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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PERMISSION

Title: Occupational Therapy Community Reintegration for Inmates with
Co-occurring Disorders

Department: Occupational Therapy

Degree: Master's of Occupational Therapy

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Signature Karen M. Allen

Date 12/13/2018

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Date 12/13/2018

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ACKNOWLEDGMENT

We, Miranda Hosking and Kara Moore, wish to express our sincere gratitude to Dr. Sarah Nielsen, Scholarly Project Advisor, for her professional guidance in carrying out this project work. We would be remiss not to acknowledge her assistance in finding resources to us, her graciousness and openness in offering constructive feedback, and her encouragement and genuine support along the way.

ABSTRACT

A co-occurring disorder (COD) is the coexistence of a substance use disorder and mental health disorder (Substance Abuse and Mental Health Services Administration, 2016). The prevalence of inmates with COD in correctional facilities is disproportionately high (Grant, Stinson, & Dawson, 2004). Despite the high incidence, correctional facilities are not equipped to meet the complex needs of individuals with COD, which often leads these individuals to re-offending or re-incarceration (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012). The role of occupational therapy in this area of practice is not clearly distinguished. However, occupational therapy's holistic, client-centered, and occupation-based principles position the profession appropriately to address the needs of individuals with COD in the forensic setting.

Therefore, the purpose of this project was to develop a product that would demonstrate the role of occupational therapy in forensic settings with a focus on addressing the needs of individuals with COD. *Occupational Therapy's Role in Community Reintegration: Continuum of Treatment for Individuals with Co-occurring Disorders from Incarceration to Community* can be used by occupational therapy practitioners to develop programming, guide intervention, or educate non-occupational therapy professionals on the role of occupational therapy in this setting.

A primary limitation of the project is that the feasibility of the product's implementation is unknown due to the variability of resources at correctional facilities. The generality of the manual may be an additional limitation of the product, as it may be

difficult for occupational therapy practitioners to apply it to a specific correctional institution. It is recommended that research is conducted to understand implementation of the product order to determine its effectiveness.

CHAPTER I

Introduction

There are roughly 2.2 million people incarcerated in the United States (Kaeble & Cowhig, 2016). Of those incarcerated, persons with co-occurring disorders (COD) are overrepresented in the criminal justice system (Peters, Wexler, & Lurigio, 2015). COD is defined as the coexistence of both a substance use disorder and a mental health disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Roughly two-thirds of jail inmates and 58% of prison inmates meet the criteria for a substance use disorder (Bronson, Stroop, Zimmer, & Berzofsky, 2017). Additionally, rates of mental illness are four to six times higher in jails and three to four times higher in prisons as compared to the general population (Prins, 2014). The overrepresentation of COD in correctional settings may be attributable to factors, including: (a) homelessness or housing instability, (b) problems finding and maintaining employment, (c) limited education, (d) lack of pro-social peer networks, and (e) pro-criminal attitudes (Morgan, Fisher, Duan, Mandracchia, & Murray, 2010).

Recidivism is a common phenomenon by which an inmate relapses into criminal behavior upon being released from a correctional facility, resulting in re-arrest, re-conviction, or a return to prison or jail (National Institute of Justice, n.d.). Persons who have COD are more likely to recidivate within one year of discharge than those with only a mental health or substance use disorder (Messina, Burdon, Hagopian, & Prendergast, 2004). Furthermore, inmates with COD who are released into the community have a 40%

higher risk of recidivism than individuals without any diagnosis (Blank, Draine, Barrenger, Hadley, & Evans, 2014). The high rates of recidivism amongst this population reflect a criminal justice system and health care system that fails to address the rudimentary problems that inmates with COD face.

Despite the significant demand to address the needs of individuals with COD, correctional settings are often ill-equipped to provide adequate care (Grant, Stinson, & Dawson, 2004). Even when inmates with COD have access to treatment, it is often not sufficient to address the complex nature of their comorbid conditions (Beck & Maruschak, 2001). Additionally, the abrupt termination of services upon release from prison or jail into the community can be detrimental to the individual's course of recovery, thereby increasing risk of recidivating. Although reforms in public policy have led to improved public safety for individuals with COD, there remains a great need for integrated services to help this population transition from the correctional institution to society effectively (Drake & Green, 2014). Therefore, the purpose of this project is to develop a product that would demonstrate the role of occupational therapy in forensic settings with a focus on addressing the needs of individuals with COD. The product was developed to be used by an occupational therapy practitioner to develop programming, guide intervention, or to assist in illustrating the role of occupational therapy to a non-occupational therapy professional.

Model Guiding Scholarly Project

The Ecology of Human Performance (EHP) model (Dunn, 2017) was chosen as the theoretical framework for this project. EHP is a holistic theory that is comprised of three interdependent constructs, including: (a) person, (b) context, and (c) tasks. The

dynamic interaction between the three components determines one's performance range (Dunn, 2017). Performance range is essentially the amount and types of occupations a person can successfully engage in based on the interaction between his or her skills, abilities, and inner motivation with the contextual supports and barriers (Dunn, 2017). Performance range can increase or decrease based on: (a) an individual's level of experience with the task at hand, (b) culture, (c) level of education, (d) motivation to complete the task, and (e) personal meanings involved with the task. Whereas individuals with high performance range can successfully engage in desired occupations and roles due to effective interactions between person, context, and task features, individuals with low performance range may struggle to engage in desired occupations due to personal limitations, contextual barriers, or difficulties in certain tasks. The overarching goal of EHP is to intervene at the level of the person, context, or task to increase an individual's performance range (Dunn, 2017).

EHP conceptualizes five intervention approaches that may be used to appropriately address person, context, and task features, comprised of: (a) establish/restore, (b) adapt/modify, (c) alter, (d) prevent, and (e) create (Dunn, 2017). Establish/restore is an intervention approach used mainly at the level of the person to establish new skills, to restore skills that are deficient, or to restore skills lost due to illness or disability. Adapt/modify is an approach used to adjust the context to support a person's engagement in occupation. Alter is also an intervention which targets the context; however, the alter approach involves completely transforming the environment as opposed to making slight changes. The prevent approach is used as a way to inhibit further disability or the exacerbation of symptoms. Lastly, the create intervention

approach is unique in that it does not assume disability and is used to promote health and wellness for all people (Dunn, 2017).

Prisoners, especially those with COD, face a variety of barriers to community reintegration upon release. Reflecting on the EHP model, inmates with COD experience a variety of deficits in relation to person, context, and task factors that greatly limit performance range. Person factors affecting performance range for this population include: (a) maladaptive routines and roles (Barrenger, Draine, Angell, & Herman, 2017), (b) inadequate coping skills (Kendall, Redshaw, Ward, Wayland, & Sullivan, 2018), (c) poor self-efficacy and self-awareness (Kendall et al., 2018), and (d) underdeveloped social skills (Johnson et al., 2013). Contextual factors that create barriers for individuals with COD consist of: (a) lack of prosocial and supportive social networks (Stahler et al., 2013), (b) difficulty finding employment (Nowotny, Belknap, Lynch, & DeHart, 2014), (c) housing instability (Nowotny et al., 2014), and (d) limited access to resources (Stahler et al., 2013). Limiting task features that are prominently evident involve: (a) unproductive leisure pursuits (Farnworth, Nikitin, & Fossey, 2004), (b) difficulty fulfilling parental and partnership roles (Baker & McKay, 2001), (c) deficiencies in home and financial management (Nowotny et al., 2014), and (d) poor health management (Ali, Teich, & Mutter, 2018). The aforementioned person, context, and task factors characteristically reflect low performance range for inmates with COD.

Also contributing to an individual's low performance range is the risk of criminality or likelihood to engage in criminal behavior, otherwise referred to as criminogenic risk. Criminogenic risk primarily encompasses the EHP construct of person. The General Personality and Cognitive Social Learning model conceptualizes eight

central factors that contribute to one's criminogenic risk (Andrews & Bonta, 2010). The eight factors include: (a) criminal history, (b) pro-criminal companions, (c) anti-social personality patterns, (d) pro-criminal attitudes and cognitions, (e) education/employment, (f) family/marital, (g) substance abuse, and (h) leisure/recreation (Andrews & Bonta, 2010). Individuals with COD disproportionately present with a combination of these risk factors. The goal of our product was to demonstrate how occupational therapy practitioners can address the needs and criminogenic risks of individuals with COD while incarcerated and throughout their transition back into the community. The product will also demonstrate the role of occupational therapy to non-occupational therapy professionals.

Key Terminology

The following terms and concepts are utilized throughout the literature review and product. Thus, we have defined the following terms for clarification.

- **Co-occurring disorder:** The coexistence of both a substance use disorder and a mental health disorder (SAMHSA, 2016).
- **Recidivism:** A common phenomenon by which an inmate relapses into criminal behavior upon being released from prison or jail into the community, which results in re-arrest, re-conviction, or a return to prison (National Institute of Justice, n.d.).
- **Criminogenic Risk:** An individual's risk of criminality or likelihood to engage in criminal behavior. According to Andrews and Bonta (2010), there are eight central factors that contribute to one's criminogenic risk, of which include: (a) criminal history, (b) pro-criminal companions, (c) anti-social personality patterns,

(d) pro-criminal attitudes and cognitions, (e) education/employment, (f) family /marital, (g) substance abuse, and (h) leisure/recreation.

- **Jail inmates:** Individuals who serve short-term sentences in a local law enforcement facility for less than one year. The time spent in jail consists of completing a sentence, awaiting a trial, or receiving a conviction that requires transferring to another correctional institution (Bureau of Justice Statistics, 2018).
- **Prison inmates:** Individuals typically with felony charges, or more severe charges, who serve sentences longer than one year. Facilities at which these individuals are confined may include state, federal, or private agencies (Bureau of Justice Statistics, 2018).
- **Custody:** The state of being physically held or confined in a correctional facility (Bureau of Justice Statistics, 2018).
- **Supported housing:** Housing options that typically involve trained staff and specialized services to provide a safe and secure home for independent living. Specifically, a primary purpose of supported housing is to support individuals with mental health needs and to provide a stable environment that will foster the process of recovery (National Housing Federation, n.d.).
- **Supported employment:** Employment support for individuals with disabilities, or individuals who require additional help, in obtaining and retaining competitive employment. Supported employment aids individuals in achieving and sustaining recovery (SAMHSA, 2014).

In the following chapter, Chapter II, this issue will be further explored through a comprehensive literature review that considers the extent of the problem an individual

with COD confronts. Once the need of the targeted population is established, Chapter III relays the methodology utilized to develop a community reintegration program from an occupational therapy standpoint. Chapter IV provides a brief overview of the product, of which is presented in its entirety in the Appendix. The concluding chapter, Chapter V, summarizes the community reintegration program and incorporates recommendations and limitations of the product.

Chapter II

Review of Literature

The United States (U.S.) has 5% of the world's population but 25% of the world's prisoners. At the year-end of 2016, nearly 2.2 million people were incarcerated in U.S. jails or prisons (Kaeble & Cowhig, 2016). Among the inmate population, health care problems are prevalent. Specifically, people with substance use disorders and mental health disorders are overrepresented in the criminal justice system (Peters, Wexler, & Lurigio, 2015). Roughly two-thirds of jail inmates and 58% of prison inmates meet the criteria for a substance use disorder, compared with 9% of the general population (Karberg & James, 2005; Bronson, Stroop, Zimmer, & Berzofsky, 2017). Additionally, rates of mental illness are four to six times higher in jails and three to four times higher in prisons than in the general population (Prins, 2014). In a survey of inmates conducted by the Bureau of Justice Statistics, it was reported that inmates with mental health problems most frequently experienced symptoms of mania (44.3%), major depression (23.1%), or psychosis (18.5%) (James & Glaze, 2006). Of the inmates with mental health problems residing in prisons or jails, approximately three-fourths of the population also met the *Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV*, American Psychiatric Association [APA], 1994) criteria for substance abuse or substance dependence as well (James & Glaze, 2006). The *Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5*, APA, 2013) replaces the terms “substance abuse” and

“substance dependence” with “substance use”; however, the most current statistic is based on the criteria of the *DSM-IV*. The coexistence of both a substance use disorder and a mental health disorder is defined as a co-occurring disorder (COD) (Substance Abuse Mental Health Services Administration, 2016).

CODs are more often the rule rather than the exception in correctional settings (Grant, Stinson, & Dawson, 2004). To accentuate this notion, it was reported that jail inmates with a mental health problem were more likely to: (a) have been a regular substance user (89.9%), (b) to have abused drugs or alcohol at least once within the month prior to their incarceration (81.6%), or (c) had been under the influence of drugs or alcohol at the time of their offense (53.8%) (James & Glaze, 2006). The overrepresentation of CODs in prison and jail settings may be attributable to many factors, including, but not limited to (a) homelessness, (b) employment problems, (c) limited education, (d) lack of supportive peer networks, and (e) criminal attitudes (Morgan, Fisher, Duan, Mandracchia, & Murray, 2010).

Inmates with CODs are more likely to: (a) stay in jail or prison longer than inmates without CODs, (b) have a current or past violent offense, (c) violate correctional rules, (d) violate conditions of community supervision, (e) become injured in institutional violence in comparison to the rest of the incarcerated population, and (f) be re-incarcerated within one year of discharge than inmates with only a mental health or substance use disorder (Messina, Burdon, Hagopian, & Prendergast, 2004). Of the individuals released from state prisons in 2005, over two-thirds were arrested within three years of release, and nearly 77% were arrested within five years of their release (Durose, Cooper, & Snyder, 2014). The nature of this reality reflects a criminal justice system that

fails to address the fundamental problems individuals with CODs experience. This also highlights the magnitude of challenges faced when attempting to confront such needs.

Whereas more than half of the offenders in U.S. jails and prisons experience, or have a history of mental illness, the majority of the population does not receive adequate treatment during their incarceration (James & Glaze, 2006). For many, jail or prison may be the first time they have access to substance abuse treatment or mental health counseling (Muñoz, 2011). Mentally ill offenders are usually released with little or no mental health aftercare planning. This is stark contrast to mentally ill hospitalized individuals who are typically released with substantial community aftercare plans (Gagliardi, Lovell, Peterson, & Jemelka, 2004).

Despite the necessity to address needs of inmates with CODs, jails and prisons are often ill-equipped to provide adequate mental health care (Grant et al., 2004). In particular, jail environments typically have less access to sufficient mental health screenings and services in comparison to prisons due to the transient nature of the environments. It was reported that roughly 66% of inmates received therapy, counseling, or medications in correctional settings that did not specialize in mental health services (Beck & Maruschak, 2001). Regardless of the quality of mental health treatment provided while incarcerated, the abrupt termination of mental health services upon release from a correctional institution can be detrimental to an individual's well-being, further impacting one's course of reintegration into the community and overall recidivism. Recidivism is a common phenomenon in which an inmate relapses into criminal behavior upon being released from prison into the community, which results in re-arrest, re-conviction, or a return to prison (National Institute of Justice, n.d.).

Offenders with CODs pose a serious problem in the criminal justice system as they lack the skills needed to make a successful transition from the prison to the community. Further, such offenders lack the strategies needed to remain out of prison (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012). Although reforms in public policy such as realignment of law enforcement and prosecution approaches, changes in sentencing laws and incarceration practices, and greater provision of resources and services for CODs, have led to improved public safety for people with CODs, there is still a great need for integrated services. Such integrated services should require strategies that: (a) prevent this population from re-entering prison or jail, (b) effectively treat these individuals if or when they are in a correctional institution, and (c) smooth the transition into the community for inmates with CODs upon release (Drake & Green, 2014).

Ecology of Human Performance

Under the scope of the Ecology of Human Performance (EHP) theoretical model, performance is a term used to represent when an individual engages in tasks within a context (Dunn, 2017). Tasks are defined as “objective sets of observable behaviors that allow an individual to accomplish a goal” (Dunn, 2017, p. 211). Throughout this paper, the term “occupations” will be used to identify meaningful activities, otherwise referred to as “tasks” by EHP. Individuals have varying levels of skills and abilities that allow them to select and engage in desired and necessary activities in such contexts.

Performance range is defined as “the number and types of tasks available to the person based on the interaction between the person’s factors (skills, abilities, and motivations) and the context variables (supports and barriers)” (Dunn, 2017, p. 212). Performance range depends on many factors including, without limitation to: (a) personal meaning of

task, (b) prior experience, (c) cultural background, (d) education, and (e) volition.

Persons with high performance range within the EHP framework are able to perform a multitude of tasks as a result of one's skills and abilities to "look through" the context (Dunn, 2017). On the other end of the spectrum, an individual with low performance range has a limited ability to perform desired tasks due to impoverished skills and abilities, which therefore implies a decreased ability to "look through" the context (Dunn, 2017).

In other words, a high performance range is the ability to adapt to contexts in order for one to carry out meaningful tasks, roles, and routines effectively. The findings of this literature review will present performance deficits and strengths categorically by client factors, performance skills, and performance patterns, all of which are subcomponents of performance.

Person

Each person who has a COD is different, and as a result experiences one's illnesses differently. Individuals with CODs, especially those who are associated with the criminal justice system, have a distinct set of barriers in their paths to recovery and their return to health. The following section of this literature review will explore the unique factors related to the performance range of individuals with CODs who are associated with the criminal justice system.

Client Factors

Client factors are defined in the *Occupational Therapy Practice Framework: Domain and Process 3rd Edition* (American Occupational Therapy Association [AOTA], 2014) as "specific capacities, characteristics, or beliefs that reside within the person and

that influence performance in occupations” (p. S7). Client factors are affected by the presence or absence of illness, disease, occupational deprivation, life experiences, situational factors, and more. Client factors are comprised of five main components: values, beliefs, spirituality, body functions, and body structures (AOTA, 2014). Values are the principles or standards that the person considers worthwhile. Beliefs are cognitive processes that the person holds as true. Spirituality refers to how individuals express meaning and connectedness to self, others, and the world. Body functions include sensory, musculoskeletal, mental, cardiovascular, respiratory, and endocrine functions. Lastly, body structures are the are the organs, limbs, and anatomical components of the body that support engagement in occupation (AOTA, 2014).

On a basic neurological level, the population of people with CODs is thought to have a genetic predisposition that puts them at a heightened risk for both substance use disorders and mental health disorders (National Institute on Drug Abuse [NIDA], 2010). Genetic experts posit that genetic code may directly lead to CODs, or indirectly cause them by leaving one with impoverished coping skills and an inadequate capacity to deal with environmental stressors (NIDA, 2010). When CODs are inadequately treated, there is a significantly increased risk of recidivism and re-incarceration (Kendall, Redshaw, Ward, Wayland, & Sullivan, 2018). Individuals with CODs have an inadequate understanding of their psychiatric problems and underdeveloped skills, in addition to a general lack of knowledge regarding leisure opportunities and resources available to help combat such deficits (Lindstedt, Soderlund, Stalenheim, & Sjoden, 2004; Robertson, 2000). Dumol (1985) ascertained that a successful and comfortable transition back into the community requires supporting and educating individuals, whom throughout their

incarceration have experienced a depreciation in the skills and confidence necessary to engage in positive leisure activities. After years of relying on staff to structure their time, prisoners noted a profound inability to constructively use free time, to access appropriate leisure resources, and to identify desired leisure activities to participate in once provided the freedom of choice (Lloyd, King, Lampe, & McDougall, 2001).

One major predictor in this population's ability to successfully re-enter society has to do with their beliefs regarding how successful they will be; in other words, their level of self-efficacy (Kendall et al., 2018). Self-efficacy is defined as one's belief in one's own capability, which influences motivation to act (Brown, 2011). As such, both unrealistically low or high self-efficacy can be detrimental to an individual's performance range (Lindstedt et al., 2004). Individuals who are able to develop insight into their CODs and identify their needs pre-release were found to have higher levels of self-efficacy and therefore better outcomes (Kendall et al., 2018). Overcoming the profound barriers of decreased self-efficacy and motivation is imperative to help inmates understand that successfully reintegrating into society is a goal they can accomplish.

Performance Skills

Performance skills are defined as "goal-directed actions that are observable as small units of engagement in daily life occupations" (AOTA, 2014, p. S7). In short, performance skills are the individual's demonstrated abilities. Performance skills have a functional purpose, they can be learned or developed through time, and different skills are used in different contexts. The three subcomponents of performance skills are motor skills, process skills, and social interaction skills (AOTA, 2014). Motor skills consist of the individual's ability to move and interact with the physical environment. Process skills

consist of the individual's sequencing, modification, and interaction with tools and materials of a task. Social interaction skills are the skills used to effectively carry out a social exchange (AOTA, 2014).

Perhaps the biggest intrapersonal barrier for prisoners transitioning into the community is their lack of coping skills, that is, the lack of processing skills related to understanding and regulating uncomfortable or painful emotional stressors (Barrenger, Draine, Angell, & Herman, 2017; Johnson et al., 2013; Kendall et al., 2018; Nowotny, Belknap, Lynch, & DeHart, 2014; Peters et al., 2015). Barrenger, Draine, Angell, and Herman (2017) found that men who were released from prison to the community were commonly met with longstanding financial and familial issues, along with a pressure to reintegrate into the community quickly. These problems often generated a daily sense of anger, frustration, and anxiety to which the men felt they were not able to adjust or cope. While many men were taking medication, they perceived the intensity of these emotions as a prominent obstacle in taking back their lives. These men felt they were ill-equipped to emotionally cope with the pressures they experienced. One man related his return to criminal activity as a result of an inability to process his emotions healthily, reporting that "getting a case of the f*ck-its" was a catalyst in his downward spiral (Barrenger et al., 2017, p. 889). This sentiment was echoed by other men as well. In other studies, some individuals actually started to believe that using substances was the only effective coping strategy they could employ (Johnson et al., 2013; McKenna et al., 2018). Unsurprisingly, the presence of positive coping skills, such as having insight into one's problems and knowing how to access resources, allows individuals to process stressors which acts as a protective factor against recidivism in the post-release period (Kendall et al., 2018).

Lindstedt, Soderlund, Stalenheim, and Sjoden (2004) pointed out the importance of addressing occupational performance within the COD population. The researchers conducted a study to determine if a discrepancy existed between how mentally-ill offenders perceive their occupational performance and social participation ability in comparison to professionals' appraisal of the same abilities. Ultimately, results indicated that the mentally-ill offenders had an insufficient understanding of their personal limitations regarding occupational performance and social participation. In particular, offenders painted a contradictory picture of their ability to engage in every day occupations. On one hand, they reported low frequencies and low satisfaction with performing occupations that were not meaningful to them. However, they conveyed high confidence for performing occupations in general.

Not only did these inconsistent views of occupational performance come from the offenders' perspective, the inconsistencies were also experienced by the professionals' perception of occupational performance (Lindsted et al., 2004). Professionals used a standardized occupational therapy (OT) assessment known as the Allen Cognitive Level Screen (ACLS). ACLS is a tool used to evaluate an individual's capacity to live an independent life in the community based on their ability to follow instructions, visually-motorically plan, as well as problem solve (Allen et al., 2007). According to results of the ACLS, almost 75% of the offenders needed various degrees of support within their community life. This result indicated limitations in a wide range of occupations. If the COD population is unaware of the extent of their limitations, negative consequences can include diminished volition to change, lack of compliance with treatment, or denial of support. This implicates that first addressing the discrepancy and lack of awareness

regarding occupational performance range will be positively influential to the success of intervention. Heightening awareness would improve motivation and compliance with treatment, which could overall enhance the COD population's engagement in the community and occupations.

Skills needed for social participation are often predictive of whether one is able to reintegrate into society successfully. Unfortunately, underdeveloped social skills are commonly seen in ex-prisoners with CODs, and inadequate social skills perturb an individual's successful reentry to the community (Ali, Teich, & Mutter, 2018; Hopkin, Evans-Lacko, Forrester, Shaw, & Thornicroft, 2018; Johnson et al., 2013; Kendall et al., 2018; Nowotny et al., 2014; Stahler et al., 2013; Van Dorn et al., 2017). It is unclear whether one's underdeveloped social skills are a result of poor functioning prior to incarceration, a consequence of long-term institutionalization, or an issue that accompanies an individual's diagnosis (Fournier, Geller, & Fortney, 2007; Kendall et al., 2018). Prisoners with CODs who return to the community commonly experience difficulty connecting to positive, supportive social networks (Kendall et al., 2018; Van Dorn et al., 2017). For women in particular, romantic relationships and parental relationships demonstrated the greatest relationship skill deficits, as they were found to be a result of limited positive social interactions in the past, and minimal opportunity to have constructive interactions in the present (Baker & McKay, 2001).

Furthermore, this population has a difficult time knowing how to communicate the need for help and how to seek assistance in acquiring resources related to treatment and housing (Barrenger et al., 2017; Hopkin et al., 2018; Johnson et al., 2013). Not knowing how to ask for help can be linked to many other factors including, but not

limited to: (a) lack of education about resources (Johnson et al., 2013), (b) stigma and the fear of being shamed for asking for help (Ali et al., 2018; McKenna et al., 2018), (c) experiencing “treatment fatigue” otherwise referred to as burnout (Johnson et al., 2013), or (d) the belief that treatment is not a priority and that one can do it on his/her own (Ali et al., 2018).

Performance Patterns

Performance patterns are the “habits, routines, roles, and rituals used in the process of engaging in occupations or activities that can support or hinder occupational performance” (AOTA, 2014, p. S8). Habits are specific and automatic behaviors. Routines are the sequences of occupations that provide structure to an individual’s life; roles are the sets of behaviors that are shaped by society, culture, and the individual; and rituals are actions with spiritual, cultural, or social symbolic meaning (AOTA, 2014). Performance patterns are embedded within the person. They are developed over time and are influenced by performance skills, client factors, the environment, and individual thought processes.

Often the post-release period is characterized by poor continuity of care, limited financial resources, and limited positive social networks that lead to the return to criminal activity (Binswanger et al., 2012). Prisoners with CODs who are released into the community are especially vulnerable to drug use and criminal activity if they continue in proximity to the same people and follow the same routine as they did prior to incarceration (Barrenger et al., 2017; Kendall et al., 2018). Researchers found that creating new sober networks upon release acted as a protective factor against recidivating (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2016). Barrenger et al. (2017) found that men

leaving prison who envisioned changing their ways were committed to doing so in two major ways: (a) avoiding old patterns and (b) doing things differently. These men believed that one of the only ways to evade getting re-involved in substance use and going back to prison was by avoiding old friends who were in the “wrong crowd”.

Financial instability was another main reason that men identified a return to using or selling drugs, as it was tempting to return to old habits to support their families and meet basic survival needs. In general, the transition from prison to the community tests resolve. These overwhelming stressors related to the changes in routines can also be related to recidivism (Barrenger et al., 2017). Avoiding known triggers such as specific people, places, and things is a protective factor against returning to prison (Johnson et al., 2013).

Another problem related to prisoners transitioning back into the community is their difficulty fulfilling the roles they used to have. These roles became extremely problematic as men returning home from prison struggled to support their families, to find new roles as employees, and to become home-owners or secure stable housing (Barrenger et al., 2017). In addition, men identified the pressure of being family provider as causing additional stress. Women on the other hand felt that the pressure of dealing with unsupportive romantic partners was a trigger to recidivate (Johnson et al., 2013) and experienced hardship fulfilling the mothering role (Baker & McKay, 2001). Women need to be provided the support and encouragement to develop adequate parenting skills that will promote bonding with their child. Regardless of gender, creating new roles such as finding new friends who are part of a sober network, becoming a volunteer, or joining a club is imperative to helping make a successful community reentry (Kendall et al., 2018).

When prisoners are able to reconnect and regain the trust and support of family members such as children, parents, and partners, they are significantly less likely to re-offend (Kendall et al., 2018; Stahler et al., 2013). Creating new healthy roles and establishing positive connections with family is just as important as letting go of toxic family relationships. Nowotny, Belknap, Lynch, and DeHart (2014) found that many prisoners with CODs are at a high risk for recidivism due to family risk exposure. Family risk exposure is assessed by family member drug use, family member incarceration history, and whether a family member helped the individual acquire drugs or alcohol before the age of sixteen. If a family member used or uses drugs, was or is currently incarcerated, or had ever helped the individual acquire drugs or alcohol before the age of sixteen the individual has a significantly higher risk of recidivating (Nowotny et al., 2014). Ultimately, finding and creating new roles in supportive, prosocial, sober networks is an important aspect of recovery (Sacks et al., 2012).

For individuals with persistent mental illness, a pattern of time use emerges in forensic environments that generally lacks leisure activity variety. For this population, engagement in leisure activities such as sleeping and watching television are predominant ways to pass the time (Farnworth, Nikitin, & Fossey, 2004). Many ex-prisoners report experiencing boredom in the post-release period because there is a void that substance use and criminal activity can no longer fill (Kendall et al., 2018; Nowotny et al., 2014). In a study conducted by Farnworth, Nikitin, and Fossey (2004), it was discovered that participants perceived their time use in one of four ways: (a) killing time, (b) making the most of it, (c) creating challenges, or (d) finding meaning within an occupation. All participants related to the notion of “killing time” to some extent. These participants

described their occupational engagement as bland and dull in comparison to their engagement in occupations prior to incarceration. Additionally, they viewed their time as a barrier to freedom rather than an opportunity to act. Furthermore, many lack prosocial attitudes and prosocial leisure pursuits in general, which many report is a gateway to returning to criminal activity and hanging around the wrong crowd (Johnson et al., 2013). Prisoners with CODs demonstrate significantly higher levels of impulsivity than the general population (Nowotny et al., 2014). When impulsivity collides with boredom and a lack of positive leisure activities, drug use and criminal activity are difficult to avoid (Johnson et al., 2013; Nowotny et al., 2014). The prominent pattern of passive leisure engagement elicits the cessation of habits that promote self-efficacy and limits opportunity for enhancing physical, mental, and social wellbeing, thereby putting individuals at risk of occupational deprivation (Farnworth et al., 2004).

Context

Much of the research regarding community reintegration for prisoners with CODs focuses on the intrapersonal and interpersonal aspects of the person. However, research demonstrates that the individuals' context has significant impacts on the ease of reintegration into the community as well. EHP defines context as a set of interrelated conditions that can either support or impede the performance of tasks, as well as have social and cultural meanings attached to them (Dunn, 2017). Physical context is comprised of natural or contrived environments, which includes the objects in them. Social context involves family, friends, institutions, and other environments in which people engage with each other. Cultural context involves factors that contribute to an individual's identity and expected social rules of behavior. Temporal context includes

aspects of life related to time such as age, development, and health. Yerxa (1983) asserted that “Successful reintegration necessitates that rehabilitation considers the biopsychosocial aspects of a person’s performances within the socio-cultural contexts where the person is expected to and wants to perform” (p. 162). Exploration of individuals’ performance within various contexts will manifest a greater understanding of the environment and how it can optimize the development of skills to facilitate community reintegration.

Temporal Context

The age of offenders in the criminal justice system has a significant relationship with the outcomes experienced both during incarceration and upon release into the community. For example, younger offenders are (a) at a heightened risk of being sexually victimized, (b) more likely to self-harm and attempt suicide, and (c) more likely to be violent (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016). In addition to young age, having shorter jail and prison sentences increases the risk of self-harm, near-lethal self-harm, and violence while incarcerated (Fazel et al., 2016). Younger offenders are also more likely to recidivate when released into the community (Stahler et al., 2013). Within the first two weeks upon release into the community, offenders with CODs have a 13-fold increase in risk for death by suicide, homicide, or drug overdose as compared to the general population (Barrenger et al., 2017). More than half of the released individuals with CODs are likely to recidivate in the first year, and about 73% recidivate by the five-year mark (Peters et al., 2015).

Social Context

The social context of an individual's life upon release into the community is often predictive of the ease of reintegration, the likelihood of return to criminal behavior, and the chances of reincarceration. Stahler et al. (2013) found that mentally ill offenders are typically challenged by reentry into the community due to the lack of prosocial values and supportive social networks. In addition, these individuals are often already socially disadvantaged due to diminished life experience from time spent in prison, as well as difficulty maintaining relationships because of intrusive mental health symptoms (Stahler et al., 2013).

The study by Johnson et al. (2013) supports that positive social networks are crucial to substance use recovery. Participants explained that their main support system included their children, significant others, and parents. Having a nonjudgmental social support system is vital to successful community reintegration and recovery. One participant related her struggle in finding social support, remarking, "I think that's the hardest thing is finding somebody who doesn't judge you" (Johnson et al., 2013, p. 8). Another important aspect of the social context for people reintegrating into the community after being incarcerated is the quality of the relationships with health care providers, case managers, parole officers, and other such professionals. Research shows that individuals have greater outcomes when they have supportive, helpful, and nonjudgmental case managers and support providers (Hopkin et al., 2018). When individuals are provided with individualized, person-centered support from professionals, they are less likely to recidivate (Hopkin et al., 2018).

Physical Context

For many prisoners with CODs transitioning into the community, the lack of stable housing and difficulty finding consistent employment have been reported as the biggest barriers to successful community reintegration (Barrenger et al., 2017; Johnson et al., 2013; Kendall et al., 2018; Nowotny et al., 2014; Peters et al., 2015; Stahler et al., 2013; Van Dorn et al., 2017). Many prisoners have unrealistic expectations that the logistical aspects of their lives, aspects related to finding a job and a home, will fall into place quickly (Johnson et al., 2013). The impatience and frustration associated with not being able to acquire employment or secure housing is often a relapse trigger. As one study participant noted, “[People] need to be warned that it won’t be easy getting out [...] In prison they made it sound like it would be easy to get services” (Johnson et al., 2013, p. 13). Another participant expressed the frustration of trying to get a job with a felony conviction on her record, saying, “No options. Real help would be to have some job getting out even if it was making sandwiches for the homeless” (Johnson et al., 2013, p. 13). Unemployment rates are comparatively high in the population of people with a criminal record, as background checks for criminal history is commonplace. Further, many ex-prisoners lack the work experience and vocational skills needed to meet the standards for many job positions (Barrenger et al., 2017).

Other individuals related the difficulty of finding housing assistance due to having drug charges, forcing them to rely on family members for assistance (Barrenger et al., 2017). Formal housing options like halfway homes, transitional houses, and homeless shelters have limited spots and are often in wretched, unlivable conditions (Barrenger et al., 2017). The financial burden of not having a job can be a trigger for the return to

criminal activity to ensure financial income and therefore satisfy basic needs (Barrenger et al., 2017). Contrarily, when individuals are able to have safe housing and get a job post-release, it promotes recovery. Employment and maintaining a home decreases boredom and fills the time that could potentially be used for alternative activities like drug use (Johnson et al., 2013). Having a job and stable housing increases self-efficacy, an individual's sense of connection to the community, and reduces the likelihood of recidivism (Johnson et al., 2013; Kendall et al., 2018).

The relationship between the physical environment and recidivism rates was explored by Stahler et al. (2013). The researchers examined the influence of neighborhood characteristics and the “spatial contagion effect” in predicting reincarceration. The spatial contagion effect is a theory positing that an individual living in close proximity to others who are reoffending will have an increased likelihood of also reoffending (Mennis & Harris, 2011). Offenders returning to neighborhoods with high levels of spatial contagion (areas with high levels of recidivism) are far more likely to be rearrested within one year of release than those in low levels of spatial contagion (Stahler et al., 2013). Part of the reason for the comparatively high levels of recidivism in these neighborhoods includes the extremely limited amount of resources, high levels of poverty, and concentrated disadvantage. Research has shown that the level of social capital in the neighborhood that a prisoner returns to may determine the likelihood of recidivating (Stahler et al., 2013). Services are often incredibly costly, and not all jurisdictions offer the services and resources that prisoners with CODs need (Nowotny et al., 2014). The challenge for community reentry programs, then, may be to equip prisoners with decision-making and assertiveness skills training before release to help

mitigate chances of falling victim to risks posed by neighborhood and physical contexts they will be returning to (Stahler et al., 2013).

Cultural Context

Contextual restrictions often manifest within forensic settings, proving as detrimental to occupational involvement for people with CODs as the illness itself. The most significant barriers identified by Farnworth et al. (2004) that substantially inhibited occupational engagement included: time constraints, limited choices, few material resources, and lack of a quiet space to engage in meaningful and relevant occupations within the facility. Opportunities within the context that were found to promote occupational participation encouraged: motivation, creativity, novelty, and challenge (Farnworth et al., 2004; Graham, Harbottle, & King, 2016). Promoting a positive therapeutic environment that encompasses the development of calm, consistent, and respectful relationships is essential (Graham et al., 2016). If an environment fosters safety, support, and inclusion, individuals are more likely to develop effective skills, achieve more positive relationships, and have improved self-confidence and self-efficacy. Aligning the context to best elicit meaningful engagement in occupations, as well as ensure a sense of stability and safety, will ultimately aid individuals to flourish in an environment that constantly battles the risk of occupational deprivation (Graham et al., 2016).

Based on the notion that drug addiction can be a result of cognitive dysfunction, poor emotional management, and underdeveloped self-reliance skills, a prison-based therapeutic community is a substance use disorder program endorsed by the U.S. criminal legal system. The program was developed to emulate an environment that promotes

commitment to moral reform and personal responsibility of its members (Kerrison, 2018). The primary goal of this intervention program is to provide an inclusive, protected space in which inmates can identify triggers that lead to substance abuse and antisocial behavior. This then increases participants' accountability and responsibility in their own recovery to end destructive behaviors and flawed reasoning processes. The purpose of the study conducted by Kerrison (2018) was to explore the extent to which differences emerge between races within the therapeutic community, and how the context may contribute to participants' adoption of racialized treatment, sobriety, and recovery outcomes.

The study discovered that Black addicts perceive themselves to be more severely impacted by the mandated intervention program, and therefore must navigate and negotiate their recovery in ways not required by their White counterparts (Kerrison, 2018). Two main concepts regarding perceptions of the racial disparities were highlighted in the study. First, Black participants were less likely to commit to the mission of the therapeutic community due to the innate cultural discrepancies of the program's design. Second, Black participants expressed not only feeling ill equipped to re-enter the community (more so than the White participants), but the belief that the institution demonstrated an intentional lack of commitment to their personal recovery and success. As a result, White participants were more likely than their Black counterparts to: (a) embrace the addict label, (b) respond better to "tough love" provided by mentors, and (c) return to more economically stable regions with greater access to healthcare resources. The study conducted by Kerrison (2018) indicated that race and culture are profound

contextual factors of a substance use disorder program, which highly impacts the outcomes of its participants.

Barrenger et al. (2017) contributed to the body of research that racial biases impact people with CODs negatively during their transition from prison to the community. Study participants in their study indicated high police scrutiny against people of color as a factor that made it difficult to avoid re-arrest. Many men reported that simply being in the wrong place at the wrong time was a very real fear, believing they would attract police attention even if they were not engaging in illegal activity. This created a sense of helplessness because “refraining from breaking the law was not enough to stay out of jail” (Barrenger et al., 2017, p. 889). Along with the feeling of helplessness some men experienced due to fear of being wrongfully re-incarcerated, researchers also noted that racial disparities included: (a) concentrated poverty, (b) inaccessibility of resources, (c) lack of collective neighborhood efficacy, and (d) employment discrimination against people of color (Barrenger et al., 2017). To combat the racialized phenomena that carry lasting consequences for individuals with CODs, mindfulness-based therapies that foster a culturally informed environment with a focus on empowering individuals from various backgrounds should be sought (Kerrison, 2018).

As the gender minority of the prison population, women are at a heightened disadvantage to recover when placed in a predominantly male facility. An overwhelming 87% of the occupational therapists surveyed in Baker and McKay (2001) agreed with the statement that “Forensic services have a legal and moral obligation to develop gender-sensitive” programs (p. 446). When a woman’s basic right to safety is jeopardized, it ultimately hinders the ability to establish trust, an essential component in the

development of a therapeutic relationship. In response to this demand for a gender-sensitive provision of care, Baker and McKay (2001) suggested a safe haven environment within the gender mixed facility. The idea of a safe haven protects women from the inherent intimidation experienced, while simultaneously improving privacy and protection from potential abuse. Ensuring a safe and supportive environment is maintained is critical to equip women inmates with the skills and knowledge necessary to become assertive and limit their experience of being a victim (Baker & McKay, 2001).

Nowotny et al. (2014) also explored the treatment needs and risk profile of women in jail with and without CODs by assessing differences in demographics, background characteristics, victimization, and family risk exposure. The results showed that women in the prison system have experienced high levels of victimization: (a) 75% of all women reported physical abuse by a family member, (b) 70% reported intimate partner violence, and (c) 62% reported experiencing sexual assault or rape. Women with CODs were significantly more likely to experience all three kinds of victimization. For example, women with CODs were 2.5 times more likely to report a history of being sexually assaulted or raped in their lifetime in comparison to women without a COD. As such, the researchers support the implementation of trauma-informed care for women prisoners, especially those with CODs (Nowotny et al., 2014).

Summary of Performance Range

To acquire an all-encompassing picture of performance range, it is imperative to explore the interaction between the aforementioned personal factors and context variables. Client factors, performance skills, and performance patterns, otherwise referred to as personal factors in the EHP model, of persons with CODs greatly impact one's

performance in various areas of occupation (Dunn, 2017). Typically, the experience of individuals with CODs is representative of the lower end of the performance range spectrum. Areas of occupation most greatly affected for this population include leisure, social participation, work, and instrumental activities of daily living (IADLs).

Engagement in passive activities like sleeping and watching television dominate leisure activity in the forensic setting (Farnworth et al., 2004). A depreciation in skills and confidence, in conjunction with a lack of knowledge on how to access leisure resources to engage in meaningful leisure opportunities, impacts an individual's quality of life while incarcerated, and also affects whether a successful transition back into the community can be achieved (Dumol, 1985; Lindstedt et al., 2004; Robertson, 2000).

Social participation is an additional area of occupation where individuals with CODs face significant deficits. A general lack of prosocial behaviors and attitudes necessary for social participation may manifest either due to a devolvement of such skills during incarceration, or as a result of skills that were never present in the first place. The depreciation, or non-existence, of social skills is considered a gateway for returning to criminal activity and former social circles upon release (Johnson et al., 2013). This lack also prevents individuals with CODs from connecting to positive, supportive social networks upon return to the community (Kendall et al., 2018; Van Dorn et al., 2017).

A component of social participation considers the skills necessary for successful interaction and fulfilment of familial roles. Men and women alike experience barriers returning to familial roles to varying extents. In particular, men returning home experience a heightened pressure associated with fulfilling the role of family provider (Johnson et al., 2013). For women, barriers were often identified in relation to coping

with unsupportive romantic partners or the struggle to satisfy the role of motherhood (Baker & McKay, 2001; Johnson et al., 2013).

Accompanying familial issues, longstanding financial insecurities compounded the likelihood that men would return to old habits in order to provide their families with basic survival needs (Barrenger et al., 2017). Alongside the IADL of financial management, men adjusting to post-release life experienced hardships with IADLs such as finding new employment and becoming a home-owner or securing stable housing (Barrenger et al., 2017). Ultimately, an individual's performance range is dependent on a multitude of personal factors in a way that intertwines with context and affects multiple areas of occupation.

Interventions

While it is ideal for a prisoner with a COD to be provided with, or connected to, treatment prior to their release (Hopkin et al., 2018; Johnson et al., 2013; Kendall et al., 2018; Peters et al., 2015), this happens less often than it should (Van Dorn et al., 2017). The reasons for the lack of treatment prior to release can be attributed to poor funding (Van Dorn et al., 2017), lack of clinically trained staff in the prison setting (Peters et al., 2015), and numerous other reasons. Most of the interventions described in research are focused around the post-release period (Hopkin et al., 2018). Occupational therapy interventions are intended to increase desired behavior amongst individuals with CODs, as well as provide them with the psychosocial skills necessary for successful reintegration into the community. Ultimately, the desired outcomes are to decrease criminal activity amongst this population, reduce recidivism rates, and ease the transition back into the community.

Comprehensive Multidisciplinary Interventions

Therapeutic communities (TC) emerged as an intensive, comprehensive substance abuse treatment in the 1960s as an alternative to the existing treatments at the time. The main tenets of TCs involve: (a) highly structured daily schedules, (b) holistic views of the person, (c) capitalization of self-help and personal responsibility, (d) the use of peers as guides within the community, and (e) the belief that the community is a healing agent and mechanism of change. TCs help individuals build skills necessary for employment and independent living while fostering prosocial ideals via the community in which the individuals reside (Sacks et al., 2012). Under the TC model of treatment, change is viewed as a gradual process rather than a sudden transformation. Community-based TCs have a long successful history of increasing employment while reducing recidivism in substance abuse offenders (Sacks et al., 2012).

Modified TC (MTC) was the first branch off the original TC model. MTCs were created to treat the needs of people with CODs rather than substance abuse alone (Sacks et al., 2012). MTCs maintain the same tenets as the TC model while adding new elements of treatment in order to address the distinct needs of individuals with CODs, such as mental illness symptoms and cognitive difficulties. The interventions involved in MTCs are: (a) individualized, (b) flexible, (c) promote more positive affirmation for meeting goals, and (d) demonstrate cultural sensitivity and competency (Sacks et al., 2012). The MTC has proven to be more effective than the traditional TC in improving rates of employment and reducing recidivism (Sacks et al., 2012).

Sacks, Chaple, Sacks, McKendrick, and Cleland (2012) is the most recent known research regarding MTCs for offenders with CODs who are transitioning from prison to

the community. The researchers found that individuals who were a part of an MTC, as opposed to those participating in customary treatment for CODs, experienced significantly lower rates of recidivism and were able to remain in the community for longer (Sacks et al., 2012). Additionally, the length of participation in the MTC was positively related to lower re-incarceration rates. Those who stayed in the MTC for longer than 90 days had a 15% re-incarceration rate, whereas those who stayed in treatment for less than 90 days had a 52% re-incarceration rate. Research demonstrates that MTCs produce the greatest outcomes for prisoners with CODs who are returning to the community (Kendall et al., 2018; McKenna et al., 2018; Nowotny et al., 2014; Peters et al., 2015).

Assertive community treatment (ACT) is a program that has long been discussed in the realm of CODs. ACT is a community treatment approach wherein individuals have access to a multidisciplinary treatment team that can help them holistically, addressing problems related to housing and employment, daily living skills, medication management, finances, and more (van Vugt, Kroon, Delespaul, & Mulder, 2014). While some research has reported that ACT is effective in reducing criminal behavior and recidivism with prisoners transitioning into the community (McKenna et al., 2018; Peters et al., 2015), there is some evidence that suggests ACT is less effective than other more commonly used treatment approaches. For example, Hopkin, Evans-Lacko, Forrester, Shaw, and Thornicroft (2018) found that individuals who were participating in ACT had a 60% rate of recidivism, whereas those working with a forensic caseworker had a 40% rate, and those enrolled in usual services had a 36% rate. This suggests that more research

needs to be done to explore the effects of ACT on the outcomes of prisoners with CODs returning to the community.

Occupation-Specific Interventions

Ar dovino, Fahey, Sprecher, and Froh (2010) conducted a study to evaluate the effectiveness of leisure education intervention in hopes to increase forensic patients' knowledge of leisure opportunities, as well as increase their skills and abilities in accessing such resources in their community upon release. Four leisure resource modules were implemented, including: (a) Leisure Resources Overview, (b) Telephone Book Use, (c) Newspaper Use, and (d) Public Library Skills. Each module consisted of multiple interactive sessions with the objective to expand the participants' current knowledge and ability to effectively navigate leisure resources. For example, the first three sessions of the Public Library Skills module probed questions of prior library experience (i.e. "Have you ever had a library card before?") and covered general information related to library etiquette (i.e. "What happens when an item you have checked out becomes overdue?") (Ar dovino, Fahey, Sprecher, & Froh, 2010, p. 35). After successfully completing the initial sessions, participants visited the local public library to reinforce the information they had obtained during the previous sessions of the module. For all four modules, a significant improvement between the pre- and post-intervention scores were found, indicating that the leisure education intervention was an effective means of developing forensic patients' ability to access and effectively utilize leisure resources.

Crabtree, Ohm, Wall, and Ray (2016) evaluated the Occupational Therapy Community Living Skills program, a program designed to aid individuals who had been imprisoned for ten or more years successfully transition to living in the community. A

participatory action research method was utilized, as three of the four researchers were incarcerated during the time of the study. The study was based on an informal education program (IEP), with each session focusing on a different topic, as well as provided group and individual session experience. Topics addressed through the program included: (a) technology, (b) socialization, (c) finances, (d) employment and health, and (e) education. A variety of educational opportunities were provided throughout the group sessions, varying from PowerPoint presentations to implementing exercises. Exercises included role playing interviews or dating situations, managing domestic situations, budgeting, or resume writing. During the individual session (conducted after the morning group session), participants were encouraged to discuss personal issues regarding the specific topic of the day and identify barriers or concerns they may have in relation to the topic upon their release from prison.

Crabtree et al. (2016) found three main themes after analyzing the participants' perspectives. These themes included: (a) doing, (b) validation of self-worth, and (c) concerns about the future. Participants expressed an appreciation for the activities that elicited an act of "doing" such as role playing and completing a resume. These opportunities allowed individuals to interact with a topic they had been out of touch with, emphasizing the importance and value of active expression for the residents' identity. For instance, one participant remarked "It brought up emotions... a lot of things that we don't deal with while we are incarcerated or we don't share with others because of the trust issues that we have when incarcerated" (Crabtree, Ohm, Wall, & Ray, 2016, p. 406).

While serving their sentence, prisoners experience a life defined by their crime. Typically, interactions are dominated by correctional staff and people convicted of crimes

(Crabtree et al., 2016). These individuals are forced to assimilate to an environment that involves an overwhelming sense of institutionalization and isolation. OT students conducted the IEP sessions over the course of the study, and the validation of self-worth theme was established through the participants' everyday interactions with the students. The OT students were referred to by many participants as "real" people, or outsiders with no agenda aside from helping the residents make a successful transition into society. One participant stated, "People just don't know how much benefit it is whenever there's outside people who come in and help. Personally, it just gives me hope for when I do re-enter society that there are still folks like that" (Crabtree et al., 2016, p. 408). Many participants additionally utilized the interactions as an opportunity to gauge their current ability to socialize with people outside of the forensic facility, often proving they could still appropriately interact and relate to individuals that were not associated with the Department of Corrections in any capacity.

The necessity of a client-centered program manifested with the IEP, as a positive response was recognized in relation to the topics recommended by participants (Crabtree et al., 2016). Responding to participant suggestions fostered a humane and caring relationship between the OT students and participants, creating a client-centered environment in which participants' self-worth was reinforced and validated.

As aforementioned, providing gender-specific provision of care to address the need of sensitivity women often desire in a therapeutic relationship was identified by Baker and McKay (2001). Access to appropriate and meaningful intervention for women was one consideration found essential in confronting this necessity. Examples of interventions to address the perceived needs of women include activities related to: (a)

assertiveness training, (b) education regarding health information (i.e. sexual health), and (c) fashion and beauty forums to build self-esteem. Once again, the importance of female-only sessions is highlighted to ensure women have the opportunity to discuss issues significant to them without judgement or criticism.

Animal-Based Interventions

A study conducted by Britton and Button (2005) explored the benefits and challenges 28 men of a medium-security prison encountered while involved with the dog training program. The training program known as Canine Assistance Rehabilitation Education and Services (CARES) is an organization that pairs inmates with dogs from the local animal shelter, dogs that are otherwise set to face euthanasia (Britton & Button, 2005). After being assigned a dog, the inmate's sole responsibility for the following 12 to 18 months is to train the dog. Throughout the course of the training, the dogs learn over 60 obedience commands and master an agility course. Once the inmates have completed training with their assigned dog, the animals are returned to CARES to find their forever homes. Individuals whom adopt the dogs must attend a week of seminars and additional training with their newly adopted pet. Recipients then attend a graduation ceremony at the correctional facility where they are afforded the opportunity to meet the inmate that trained their canine.

The top three motivations for inmates to become involved in the dog training program in the first place included: (a) a love for dogs, (b) the freedom afforded to dog trainers (i.e. access to a fenced dog yard and agility course), and (c) a sense of giving back to the community (i.e. some men viewed training dogs as one way to combat the harm they had caused in the community by their criminal offenses) (Britton & Button,

2005). In terms of challenges, inmates felt a sense of hyper-surveillance from the guards, and as a result were watched more closely than their counterparts not involved with the program. Conflict that arose between other inmates' interactions with the dogs was another challenge identified in the study. If non-dog trainers would fail to respect the rule of only petting the dog if granted permission, or if the safety of the dog was at risk, a protective response was often elicited from the dog trainers. Lastly, saying goodbye to the dogs after developing a strong emotional bond over the course of training proved a particularly trying feat for the inmates.

Although challenged with trying times, benefits of the dog training experience were noteworthy. Inmates reaped personal therapeutic value in developing a trusting relationship with the dogs and most perceived a positive change in their attitudes and emotions (Britton & Button, 2005). The dogs helped teach inmates how to deal with anger, the virtue of patience, and provided unconditional love in an environment that consistently lacks such comradery. Participants additionally noticed a positive change in the institutional climate, as the dogs influenced an optimistic, calming mood that normalized the atmosphere. The most profound benefit of the program, however, was the overwhelming sense of purpose afforded to the inmates in a worthwhile experience to give back to their community. One participant reinforced this notion, reflecting on his experience attending a graduation: "Like this one [girl] she's in a wheelchair and she wasn't real mobile at all... and that dog was just listening to her and it was like 'Wow!' Just for them to say something and the dog does exactly what it's supposed to do, that's why I stay in it, that's why I continue to train them ... We're providing animals for individuals [who need them]. That's the best part" (Britton & Button, 2005, p. 93).

Ultimately it was concluded that dogs have the potential to transform lives of individuals serving time in a correctional facility (Britton & Button, 2005).

In a similar sense, a study conducted by Fournier, Geller, and Fortney (2007) explored the impact of a dog training program in relation to criminal behavior and social variables. The dog training program greatly paralleled the program employed by CARES, in which inmates trained shelter dogs to prepare them for eventual adoption in the community. It was found that providing for the basic needs of another living creature proved highly beneficial for the inmates in terms of (a) increased involvement in the therapeutic community, (b) decreased criminal behavior, and (c) improved social skills. The pre- and post-test design of the study allowed for the analysis of inmate participation in a compare and contrast fashion. Inmates involved in the program had reduced criminal behavior when comparing their markups before experiencing the animals to after. This is particularly notable as correctional staff are typically stricter with inmates involved in the program, reportedly citing program participants with infractions for less serious offenses than their inmate counterparts not involved in the program.

Lastly, inmates that trained a dog companion demonstrated significant improvement from pre- to post-test in the area of social behavior, or more specifically, social sensitivity (Fournier et al., 2007). Social sensitivity is the ability to interpret verbal communication, as well as demonstrate insight into appropriate social behavior that aligns with social norms. Whereas program participants improved in this area, the inmates not involved in the program actually demonstrated a decline in social sensitivity between pre- and post-test measures. This poses a

grander question of whether all inmates face a general decline in social sensitivity throughout their incarcerated experience, and if involvement with animals plays a role in stunting, or even combatting, this potentially inevitable decrease in social skill.

Outcome Measures

For years, there has been a call for the development of forensic setting-specific outcome measurement tools. Fan, Morley, Garnham, Heaseman, and Taylors (2016), examined the effectiveness of an existing OT assessment tool. The Model of Human Occupation Screening Tool (MOHOST) was implemented in low and medium security units to analyze the occupational participation of incarcerated individuals over the span of two years (Parkinson, Forsyth, & Kielhofner, 2006). The MOHOST was administered every six months, measuring occupational performance in terms of: motivation for occupation, pattern of occupation, communication/interaction skills, process skills, motor skills, and environment. Results of the study indicated that the participants' overall occupational participation improved over time. In particular, five of the six MOHOST subdomains demonstrated clinical significance. The only subdomain that did not show improvement was the motor skills category. It was further revealed that patients from low-security settings had higher average scores in each of the MOHOST subdomains, and overall MOHOST total scores, than those from medium-security settings. This implicates that patients in low-security settings have more positive and active occupational participation than individuals residing in a medium-security facility

Similarly, the Occupational Performance History Interview (OPHI-II) was selected as an outcome measure in Farnworth et al. (2004) due to its emphasis on

temporal and historical perspectives (Kielhofner et al., 1998). The semi-structured interview format of the OPHI-II was used in conjunction with time diaries to analyze time use of the participants in an institutional context (Farnworth et al., 2004). By use of these together, it was discovered that learning about one's prior occupations and life history was beneficial to understanding one's current occupational choices, interests, and the various personal meanings associated with certain occupations. Overall, the OPHI-II proved highly valuable in better understanding individuals' skills, capacities, and self-efficacy in regard to occupational history, which further benefited current occupational performance within the forensic context.

Despite the lack of forensic specific outcome measures, current OT derived tools can provide adequate evaluation of individuals with CODs in the forensic setting. Routine outcome measurements in a forensic setting are imperative to help describe the intervention process, identify incarcerated individuals' strengths, as well as address their ongoing and dynamic needs. An occupational therapist in a forensic setting must regularly and thoroughly assess such needs through a means like the MOHOST or OPHI-II to ensure interventions are tailored to the individual, and that engagement in meaningful occupations is occurring (Fan, Morley, Garnham, Heaseman, & Taylors, 2016; Farnworth et al., 2004).

Conclusion

The relationship between person and context is paramount to an individual's occupational engagement. For individuals experiencing a COD while incarcerated, the complexity of this interdependent relationship is amplified. Establishing or restoring performance skills and performance patterns will not only enable individuals to

reintegrate into society successfully, but ultimately remain out of jail or prison as well. In helping individuals evade pre-incarceration habits and routines, it is essential that a program must be designed to: (a) promote self-efficacy and motivation, (b) teach coping and social skills, and (c) provide the tools necessary for the continuity of meaningful roles as mother, father, significant other, or employee.

There is an insufficient supply of OT-based interventions to combat the injustice and occupational deprivation that manifests within the criminal justice system. Contextual barriers created by this system are all contributing factors to the inexcusably high rates of recidivism. Some of these barriers include, but are not limited to: lack of resources, inadequate space, poor cultural and gender sensitivity, as well as ill preparation for helping individuals with CODs return to pre-incarceration contexts.

Comprehensive and multidisciplinary interventions, occupation-specific interventions, and animal-based interventions are found to be effective means of promoting the development of life skills, enhancing occupational performance, and facilitating engagement in the community. As the country with the largest prison population in the world, a call to promote a criminal justice system that works with the inmates, rather than against them, is mandatory to reduce the escalating recidivism rates. Occupational therapists are equipped with a unique skill set that can help address the multifarious aspects of an incarcerated individual experiencing a COD to overcome occupational deprivation, promote occupational justice, enhance personal well-being, and improve overall quality of life.

CHAPTER III

Methodology

Initially, the authors of this project were interested in developing a product that would help occupational therapy practitioners address the needs of prisoners in correctional facilities. During the beginning stages of our research, it was discovered that there is a prevalent problem within the criminal justice system regarding inmates with COD specifically. Upon further research, it was revealed that inmates with COD experience a variety of occupational performance problems, which negatively impacts their course of reintegration into the community. Once these occupational deficits were recognized, a literature review was conducted to advance understanding of the extent of the issue. Literature articles were gathered from a search of various electronic databases including PubMed, CINAHL, PsychInfo, SocINDEX, and Cochrane. Key terms used to guide the search consisted of “occupational therapy,” “co-occurring disorders,” “recidivism,” “criminogenic risk,” “community reintegration,” and “incarceration.”

Information from the literature review was analyzed and structured using the Ecology of Human Performance (EHP) model (Dunn, 2017) in conjunction with the *Occupational Therapy Practice Framework: Domain and Process 3rd Edition* (American Occupational Therapy Association, 2014). The EHP model was chosen for a variety of reasons, one of which is due to the emphasis placed on the person, context, and tasks, and how the interaction of these concepts determines performance range. This ecological model accentuates the importance of considering the context, which was discovered to be

a critical component of successful community reintegration for an individual with COD (Dunn, 2017). In addition, EHP provides five distinct intervention approaches to help structure the intervention planning and implementation process. Furthermore, EHP uses easily understandable terminology, providing the interdisciplinary team with a common language to enhance communication, thereby facilitating efficient coordination of care.

Findings of the literature review were categorized under the EHP concepts of person, context, and task. In accordance with the model, information relating to the person included values, interests, skills, roles, habits, and routines. The context was described from cultural, temporal, physical, and social aspects. While we did not create a task section, information about tasks was interwoven throughout the person and context sections, demonstrating that the interactions between tasks with the personal and contextual factors are inextricably bound.

While completing the literature review, we discovered a manual created by the Substance Abuse and Mental Health Services Administration (SAMHSA) titled *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (2017). This manual illustrates a multidisciplinary approach used in the treatment of individuals with COD during the transition from correctional facilities to the community. Although an impeccable resource, the role of occupational therapy was not delineated nor mentioned, revealing a paramount gap in care regarding the occupational needs of a highly volatile population. SAMHSA (2017) outlined ten guidelines encompassing the continuum of treatment starting from initial incarceration and ending in the transition back into the community. Our product aims to supplement the manual created by SAMHSA (2017) by

demonstrating occupational therapy's unique contribution in order to close the ostensible disconnect between the occupational needs of individuals with COD and the services actually being provided.

The manual produced by SAMHSA (2017) categorized the ten guidelines into four sections following the Assess-Plan-Identify-Coordinate (APIC) model. "Assess" refers to the process at the beginning of an individual's incarceration experience where the interdisciplinary team members conduct screens and assessments to gather information regarding the individual's clinical and social needs, as well as public risk. Once the assessment data is obtained, the "Plan" stage of the model consists of the provision of treatment and services to address the identified needs. The next section, "Identify," considers the community resources and supports the individual will need post-release. Lastly, the "Coordinate" section aims to maximize the continuity of care by coordinating transition plans. Within the sections of the occupational therapy-centered manual, multiple tables and one figure were created to help depict occupational therapy's role in correlation with the guidelines set forth by SAMHSA (2017).

To assist with the guideline addressing the "Assess" aspect of the APIC model, the *Screening and Assessment of Co-Occurring Disorders in the Justice System* (SAMHSA, 2015) was additionally used as a resource. The manual indicates a plethora of multidisciplinary screening tools valuable for gathering information with regard to: (a) COD, (b) mental disorders, (c) substance use disorders, (d) suicide risk, (e) traumatic life events/post-traumatic stress disorder, (f) motivation/readiness for treatment, and (g) risk of recidivism/criminal behavior.

CHAPTER IV

Product

In correlation with the 10 multidisciplinary guidelines the Substance Abuse and Mental Health Services Administration (SAMHSA; SAMHSA, 2017) outlined in regard to the continuum of treatment necessary for individuals with co-occurring disorders (COD), the *Occupational Therapy's Role in Community Reintegration: Continuum of Treatment for Individuals with Co-occurring Disorders from Incarceration to Community* was developed. This manual was created with the purpose to delineate and demonstrate the role of occupational therapy in conjunction with the guidelines established by SAMHSA (2017). As such, the manual serves as a guide for occupational therapy practitioners working within a criminal justice facility to provide occupation-based and client-centered treatment to supplement the assessment, intervention, and transition process already identified from a multidisciplinary approach. Moreover, the manual simultaneously serves as a means to illustrate the role of occupational therapy to non-occupational therapy professionals. To maintain consistency, the product was similarly divided into four sections based on the Assess-Plan-Identify-Coordinate (APIC) model (SAMHSA, 2017). After the presentation of the 10 guidelines from the occupational therapy perspective, a case study was included towards the end of the manual to encourage the reader to critically analyze and apply the occupational therapy-derived guidelines to a specific scenario.

A variety of methods were employed throughout the development of the 10 guidelines, consisting of: (a) narrative style, (b) table configurations, and (c) construction of a figure. The guideline specified by SAMHSA (2017) was presented at the beginning of each occupational therapy-based guideline to help the reader draw parallels between the multidisciplinary approach and how occupational therapy can contribute to and positively supplement the current standards. The Ecology of Human Performance (EHP) model (Dunn, 2017) was regularly reflected throughout the guidelines to emphasize the importance of considering the person, context, and task in providing high-quality care along the continuum. The following list provides a brief overview of the tables and figure presented in the product.

- **Table 1:** Identifies 17 multidisciplinary screening tools from *Screening and Assessment of Co-Occurring Disorders in the Justice System* (SAMHSA, 2015) that occupational therapy practitioners would be qualified, or could easily be trained, to administer. Within this table, it is indicated which EHP concepts and criminogenic risk factors the screening tool would be useful in obtaining information in.
- **Table 2:** Introduces and describes a variety of occupational therapy-based assessments that would be useful in obtaining information to drive client-centered intervention. EHP concepts are also reflected within this table.
- **Table 3:** Indicates how the occupational therapy-based assessments relate to criminogenic risk factors.
- **Table 4:** Provides an implementation guideline for administration of occupational therapy assessments. The implementation guide reflects three different

timeframes, of which include: (a) custody, (b) time of release, and (c) post-release. The table also identifies whether the assessment would be a valuable tool for re-evaluation.

- **Table 5:** Presents suitable occupational therapy-based interventions, of which are categorized based on the five EHP intervention approaches.
- **Table 6:** Identifies which criminogenic risk factors are targeted by the occupational therapy interventions.
- **Figure 1:** Indicates the risk level of an individual with COD (high, medium, or low risk), which helps further inform the level of supervision and level of support an individual would need in accessing community resources.

The product in its entirety can be found in the Appendix.

CHAPTER V

Summary

The purpose of the scholarly project was to create a product that would demonstrate the role of occupational therapy in forensic settings with a focus on addressing the needs of individuals with co-occurring disorders (COD). The product was constructed with the intent to be used by an occupational therapy practitioner to aid in program development, guide intervention, or to illustrate the role of occupational therapy to a non-occupational therapy professional.

Product

The product, *Occupational Therapy's Role in Community Reintegration: Continuum of Treatment for Individuals with Co-occurring Disorders from Incarceration to Community*, was developed to reflect occupational therapy's role in accordance with the guidelines created by the Substance Abuse and Mental Health Services Administration (SAMHSA; SAMHSA, 2017). Within this manual, SAMHSA (2017) outlined the multidisciplinary approach in 10 guidelines to demonstrate the crucial importance of a continuum of care for inmates with COD who are transitioning from correctional facilities to the community. The 10 guidelines are presented throughout four different sections following the Assess-Plan-Identify-Coordinate (APIC) model (SAMHSA, 2017).

The APIC model assists the occupational therapy practitioner in assessing the inmates clinical and social needs, planning intervention based on their determined needs,

identifying necessary community supports and resources the individuals will need upon release, and coordinating transition plans to ensure continuity of care is achieved from incarceration to community. The occupational therapy-based assessments, interventions, and community reintegration care plans reflect the constructs of the Ecology of Human Performance (EHP) model (Dunn, 2017), as well as the criminogenic risk factors (Andrews & Bonta, 2010). After presenting occupational therapy's unique role in relation to the 10 guidelines (SAMHSA, 2017), a case study followed by a series of questions was developed to help the reader critically analyze and apply the concepts introduced throughout the manual. The authors of the manual provide potential responses to the posed case study questions in the Appendix, which encourages the reader to personally reflect and respond to the questions independently prior to viewing the provided answers.

Strengths

The product has several strengths regarding the valuable perspective the field of occupational therapy has to offer individuals with COD. The product serves as a framework for screening, assessment, intervention planning, intervention implementation, and considers community outreach, all of which occupational therapists working in a forensic setting could have a distinguished role in fulfilling. It also delineates the role of occupational therapy to professionals who do not understand what occupational therapy can do in this area of practice. Further, the product provides guidelines on how to increase continuity of care between services provided in correctional settings and the services within the context of the community. The product also clarifies the role of occupational therapy with relation to the interdisciplinary team in a forensic setting, ensuring holistic evaluation and treatment of inmates with COD is

consistently achieved. Finally, the product is underpinned by the EHP theoretical model. EHP uses interdisciplinary-friendly language and emphasizes the importance of addressing the person, context, and task factors to increase an individual's performance range. Having EHP to guide the process of treatment will increase coordination between disciplines and streamline the assessment, intervention planning, and intervention implementation processes to produce the best outcomes for inmates with COD.

Limitations

There are some identifiable limitations to the product. First, the product was created by two occupational therapy students, with the help of their advisor, none of whom have substantial clinical experience implementing occupational therapy in criminal justice settings. In addition, our product has not yet been utilized in practice, thus the utility and ease of the manual's implementation is unknown. Given that every correctional facility operates under different rules and regulations, and the availability of resources differs at each facility, it is difficult to predict the feasibility of the product's implementation. While the product's generality is one of its strengths, it can also be a barrier. For example, it may be difficult for occupational therapy practitioners to conceptualize how to specifically utilize the manual's guidelines in a particular facility.

Recommendations

It is recommended that research is conducted to understand how the product is implemented in correctional facilities in order to determine its effectiveness and usefulness. The researchers recommend that occupational therapy practitioners use the product as a broad guideline for practice and utilize their clinical judgment and reasoning to implement suggestions as necessary. Furthermore, it is recommended that occupational

therapy practitioners working in forensic settings use the product, identify areas needing improvement or clarification, and provide feedback to the researchers to advance the product in the future.

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APPENDIX

*Occupational Therapy's Role in
Community Reintegration:
Continuum of Treatment for Individuals
with Co-occurring Disorders from
Incarceration to Community*

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Introduction to Manual

The Substance Abuse and Mental Health Services Administration (SAMHSA; SAMHSA, 2017) has created the *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* to provide examples of successful strategies that have been employed for transitioning people with mental health disorders, substance use disorders, or co-occurring disorders (COD) from correctional settings to the community. The implementation guide can be used by behavioral health professionals, community stakeholders, and professionals in correctional settings. The high incidence of mental health disorders, substance use disorders, and COD in incarcerated persons creates various problems for both the individual and the justice system as a whole. Often, inmates with mental health disorders or substance use disorders lack access to the services they need upon release from jail or prison, which can lead to the individual recidivating or re-offending and becoming ensnared in costly justice system involvement (Pew Center on the States, 2011). SAMHSA's (2017) implementation guide is aimed to increase the continuity of services from the institutional setting to the community setting in order to prevent the cycle of recidivism and facilitate successful reintegration.

There is a lack of clarity regarding the role of occupational therapy in the transition from correctional settings to the community as it is a relatively uncharted emerging area of practice. Essentially, the profession of occupational therapy has not carved out a distinct role for itself within the criminal justice system, nor has it developed guidelines on how occupational therapy practitioners can specifically address the problems inmates with COD experience upon returning to the community. Although the

occupational therapy role is ill-defined and literature is sparse, there is evidence supporting occupation-based interventions for this population. Occupational therapy interventions have elicited positive outcomes in areas of occupation such as: (a) instrumental activities of daily living (IADLs), (b) social participation, (c) work, and (d) leisure (Ardovino, Fahey, Sprecher, & Froh, 2010; Baker & McKay, 2001; Crabtree, Ohm, Wall, & Ray, 2016). Literature has also established that occupational therapy assessments are an effective means of evaluation for individuals within the criminal justice system, as the tools maintain client-centered, occupation-based perspectives (Fan, Morley, Garnham, Heaseman, & Taylors, 2016; Farnworth, Nikitin, & Fossey, 2004; Lindstedt, Soderlund, Stalenheim, & Sjoden, 2004).

The manual being presented is complementary to SAMHSA's (2017) implementation guide and its purpose is to inform occupational therapy practitioners and other professionals how occupational therapy can play a valuable role in the screening, evaluation, and intervention of people with COD who are transitioning from prison or jail into the community. The manual is divided into four main sections consistent with the outline of the SAMHSA (2017) implementation guide, delineating the potential roles occupational therapy practitioners can undertake. The four sections comprise:

1. *Assess the individual's clinical and social needs and public safety risks* (Guidelines 1 & 2)
2. *Plan for the treatment and services required to address the individual's needs (while in custody and upon reentry)* (Guidelines 3 & 4)
3. *Identify required community and correctional programs responsible for post-release services* (Guidelines 5 & 6)
4. *Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services* (Guidelines 7, 8, 9, & 10)

This manual is underpinned by the Ecology of Human Performance (EHP) model. Occupational therapy practitioners are trained to view people from a holistic, client-centered perspective that allows them to address not only the physical and contextual demands of participation in occupation, but also the psychosocial factors and criminogenic risks that affect one's participation and function in everyday activities (Dunn, 2017). The EHP model provides a beneficial framework to address these aspects of an individual's performance, which are reflected in the main concepts of the model: (a) person, (b) context, and (c) task. Within this model, a person is recognized as an individual composed of a unique configuration of abilities; past experiences; personal values and interests; and sensorimotor, cognitive, and psychosocial skills (Dunn, 2017). The interrelated conditions that envelop a person are referred to as context. Tasks are defined as "objective sets of observable behaviors that allow an individual to accomplish a goal" (Dunn, 2017, p. 211).

Performance range is another key concept of the EHP model and is illustrated as the transaction between person factors and context variables in order to engage in tasks (Dunn, 2017). An individual's performance range is fluid and fluctuates depending on the interaction between the person and context. A high performance range is the ability to adapt to contexts in order for one to carry out meaningful tasks, roles, and routines effectively. However, low performance range is marked by a limited ability to perform desired tasks due to impoverished skills and abilities (Dunn, 2017). Increasing the performance range for individuals with COD is the desired outcome of this manual.

Assess the individual's clinical and social
needs and public safety risks

Guideline 1

Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used (SAMHSA, 2017).

Screening for COD is utilized to identify problems related to mental health, substance use, trauma/post-traumatic stress disorder (PTSD), or criminogenic risk (SAMHSA, 2015). Criminogenic risk, or risk of criminality, is thought to be primarily resulting from personal factors. The General Personality and Cognitive Social Learning model conceptualizes four big factors and four moderate factors that contribute to the risk of criminality, all of which are commonly known as the central eight risk/need factors (Andrews & Bonta, 2010). The four big factors include: (a) criminal history, (b) pro-criminal companions, (c) anti-social personality patterns, and (d) pro-criminal attitudes and cognitions. The four moderate factors consist of: (a) education/employment, (b) family/marital, (c) substance abuse, and (d) leisure/recreation (Andrews & Bonta, 2010).

Screening for COD, in conjunction with assessing the symptoms and behaviors associated with such disorders, will provide the occupational therapy practitioner with relevant information needed to guide a comprehensive evaluation of the individual's occupational performance. Table 1 provides examples of multidisciplinary screening tools suggested in *Screening and Assessment of Co-Occurring Disorders in the Criminal Justice System* (SAMHSA, 2015) that occupational therapy practitioners are qualified to administer, or can be trained to administer, in order to gain insight into the inmate's

COD, substance use, role functioning, history of trauma, suicide risk, or risk for recidivism and criminal behavior.

The multidisciplinary screening tools presented in Table 1 are focused on identifying the immediate needs of individuals with COD upon entry into the criminal justice system. With the exception of one tool that addresses contextual factors, all screening tools found in Table 1 address person factors of the EHP model. Evidently, there is a lack of screening tools used to evaluate both contextual and task factors. Furthermore, the screening instruments identified by SAMHSA (2015) have been categorized based on the key criminogenic risk factors commonly addressed during the transition from prison or jail to the community in Table 1. Of these screening instruments, the number that address criminogenic risk factors is as follows: (a) 12 for criminal history, (b) 11 for pro-criminal companions, (c) 17 for anti-social personality patterns, (d) 17 for pro-criminal attitudes and cognitions, (e) seven for education/employment, (f) 11 for family/marital, (g) 15 for substance abuse, and (h) 12 for leisure/recreation. Overall, Table 1 includes: (a) two COD screening tools, (b) three mental disorder screens, (c) three substance use disorder screens, (d) two suicide risk screens, (e) four traumatic life events/PTSD screens, (f) two screens for motivation and readiness for treatment, and (g) one screen addressing risk of recidivism and criminal behavior.

While providing valuable information, the screens found in Table 1 fail to assess function and performance in occupations, and the roles recognized as meaningful to the person. Under Guideline 2, occupational therapy assessments will be introduced that can be used to supplement the areas in which the screening tools alone fall short.

Table 1: SAMHSA Guideline 1 Multidisciplinary Screening Tools in Relation to EHP
(SAMHSA, 2017)

Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

	<p>* = instrument that addresses person factors</p> <p>** = instrument that addresses contextual factors</p> <p>*** = instrument that addresses task factors</p>	<p>¹ = Criminal History</p> <p>² = Pro-criminal Companions</p> <p>³ = Anti-Social Personality Patterns</p> <p>⁴ = Pro-Criminal Attitudes & Cognitions</p> <p>⁵ = Education/Employment</p> <p>⁶ = Family/Marital</p> <p>⁷ = Substance Abuse</p> <p>⁸ = Leisure/Recreation</p>	
	<p>Screening Instruments for Co-occurring Mental and Substance Use Disorders:</p>	<p>Screening Instruments for Mental Disorders:</p>	<p>Screening Instruments for Substance Use Disorders:</p>
<p>Multidisciplinary Screening Tools (SAMHSA, 2015)</p>	<p><u>Behavior and Symptom Identification Scale</u>* ^{2, 3, 4, 5, 6, 7, 8}</p> <ul style="list-style-type: none"> • 24-item self-report measure. • Functional domains: interpersonal relations, self-understanding, role functioning, daily living skills, substance use, and impulsivity. • Psychopathology: mood disturbance, anxiety, suicidality, and psychosis. 	<p><u>Beck Depression Inventory – II</u>* ^{1, 3, 4, 5, 6, 7, 8}</p> <ul style="list-style-type: none"> • 21-item self-report instrument. • Assesses intensity of depressive symptoms and suicidality. <p><u>Center for Epidemiological Studies – Depression Scale</u>* ^{3, 4, 5, 6, 7, 8}</p> <ul style="list-style-type: none"> • 20-item self-report screen. • Examines frequency and duration of symptoms associated with depression in the past week. 	<p><u>Drug Abuse Screening Test</u>* ^{1, 2, 3, 4, 7, 8}</p> <ul style="list-style-type: none"> • Examines symptoms of substance abuse and drug and alcohol use over past 12 months. <p><u>Simple Screening Instrument for Substance Abuse</u>* ^{1, 2, 3, 4, 7, 8}</p> <ul style="list-style-type: none"> • 16-item screening instrument that examines severe alcohol and drug use disorders in past 6 months. • Domains include: alcohol and drug consumption, preoccupation

	<p><u>Global Appraisal of Individual Needs</u>* 1, 2, 3, 4, 5, 6, 7, 8</p> <ul style="list-style-type: none"> • Examines psychosocial issues related to mental and substance use disorders. • 20-items, 4 subscales: internal disorders, behavioral disorders, substance use disorders, and crime and violence. 	<p><u>Brief Symptom Inventory</u>* 1, 3, 4, 5, 6, 7, 8</p> <ul style="list-style-type: none"> • 53-item self-report screen. • Determines number of symptoms, level of psychological distress, and intensity of symptoms. • Can measure progress over time. 	<p>and loss of control, adverse consequences, problem recognition, and tolerance and withdrawal.</p> <p><u>Texas Christian University Drug Dependence Screen Y</u>* 1, 2, 3, 4, 7, 8</p> <ul style="list-style-type: none"> • 17-item self-report measure. • Examines motivation for treatment, history of treatment, substance use disorder symptoms, frequency of substance use, and severity of substance use.
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Table 1: SAMHSA Guideline 1 continued

Screening Instruments for Suicide Risk:	Screening Instruments for Traumatic Life Events/PTSD:	Screening Instruments for Motivation and Readiness for Treatment:	Screening Instruments for Risk of Recidivism & Criminal Behavior:
<p><u>Interpersonal Needs Questionnaire (INQ)/Acquired Capability for Suicide Scale (ACSS)</u> * 1, 2, 3, 4, 6</p> <ul style="list-style-type: none"> • 2 self-report instruments. • INQ assesses feelings of burdensomeness and lack of belonging. • ACSS measures suicide capability. <p><u>Beck Scale for Suicidal Ideation</u> * 1, 3, 4, 6</p> <ul style="list-style-type: none"> • 21-item self-report scale. • Examines 	<p><u>Life Stressor Checklist</u> ** 1, 2, 3, 4, 5, 6, 7, 8</p> <ul style="list-style-type: none"> • Self-report measure that assesses stressful life events. • 30 items about exposure to traumatic events, including natural disasters, accidents, physical/sexual abuse, and other stressful life events (such as divorce, foster care, and financial difficulties). <p><u>Trauma Symptom Inventory</u> * 1, 3, 4, 6, 7, 8</p> <ul style="list-style-type: none"> • 100-item self-report inventory. • Evaluates presence of acute and chronic trauma. • Examines affective, cognitive, and physical 	<p><u>University of Rhode Island Change Assessment Scale</u> * 2, 3, 4, 7</p> <ul style="list-style-type: none"> • 24, 28, and 32-item versions of self-report questionnaire. • Examines motivation and readiness for treatment. • 24-item version has been adapted to be used with COD population. • Uses simpler language, defines problems identified by the respondent, and can be administered as an interview for those with literacy or sight problems. • 4 scales examine the trans-theoretical stages of change. <p><u>Texas Christian University Motivation Form</u> * 2, 3, 4, 7</p> <ul style="list-style-type: none"> • 36-item instrument that 	<p><u>Level of Service Inventory – Revised</u> * 1, 2, 3, 4, 5, 6, 7, 8</p> <ul style="list-style-type: none"> • 54-item risk/need assessment that addresses psychosocial problem areas in an individual's life, forecasts criminogenic risk, aids in the allocation of resources, fosters decision-making with regard to probation and placement, and serves as a re-evaluation tool during the treatment process.

<p>thoughts, plans, and intent to commit suicide.</p> <ul style="list-style-type: none"> • Inquiries about the desire to live, suicidal intent, plans and preparation for suicide, and openness about sharing suicidal thoughts to others • Examines frequency and severity of past suicide attempts. 	<p>issues related to trauma. <u>Trauma Symptom Checklist</u>*^{1, 2, 3, 4, 6, 7, 8}</p> <ul style="list-style-type: none"> • 40-item self-report measure of PTSD and associated symptoms related to events occurring throughout the lifespan. • 6 scales include: anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbance. <p><u>Primary Care PTSD Screen</u>*^{1, 2, 3, 4, 6, 7}</p> <ul style="list-style-type: none"> • 4-item screen for PTSD in primary care settings. • Includes re-experiencing a traumatic event, emotional numbing, avoidance, and hyperarousal. • Once screened, client should receive further assessment by expert in field. 	<ul style="list-style-type: none"> • examines readiness for change, motivation, and readiness for treatment. • 5 scales include: problem recognition, desire for help, treatment readiness, pressures for treatment, treatment needs, and accuracy. 	
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- All assessments available at <https://store.samhsa.gov/shin/content/SMA15-4930/SMA15-4930.pdf>

Guideline 2

For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on: (a) basic demographics and pathways to criminal involvement, (b) clinical needs, (c) strengths and protective factors, (d) social and community support needs, and (e) public safety risks and needs (SAMHSA, 2017).

After screening is complete, comprehensive assessments are necessary to attain more detailed information to help further inform the intervention process (SAMHSA, 2015). Occupational therapy assessments are complementary to the aforementioned screenings due to their significant focus on function in everyday life, as well as their ability to reflect holistic care by addressing the person, context, and task (Dunn, 2017). Therefore, occupational therapy practitioners are equipped to administer such assessments to help identify occupational deficits, performance skills/patterns, and client factors that contribute to the low performance range of an individual with COD. Understanding the detrimental underlying performance issues, in conjunction with recognizing an individual's interest, values, and motivation, will serve as a guiding force to maximize performance range of an individual with COD.

Determining which assessments should be implemented is dependent on a variety of factors, some of which may include: (a) the needs of the individual with COD, (b) setting, and (c) the model of practice serving as the theoretical foundation of treatment (White, Grass, Hamilton, & Rogers, 2013). Various assessments derived from the field of occupational therapy have the potential to contribute and provide supplemental knowledge necessary to obtain an adequate understanding of an individual with COD.

Table 2 provides various potential occupational therapy-specific assessments, defines the purpose of each assessment, and indicates which component of EHP is being addressed (person, context, task, or a combination of these concepts). Of the 11 assessments presented in Table 2, 10 address person factors, six evaluate contextual factors, and eight assess task factors.

Table 3 delineates which occupational therapy-specific assessments would be beneficial for gathering information with regard to specific criminogenic risk factors. The occupational therapy assessments are versatile in nature and can be utilized to generate assessment information applicable to more than one risk factor. The breakdown of occupational therapy assessments targeting the eight criminogenic risk factors is as follows: (a) two for criminal history, (b) five for pro-criminal companions, (c) nine for anti-social personality patterns, (d) four for pro-criminal attitudes and cognitions, (e) nine for education/employment, (f) ten for family/marital, (g) six for substance abuse, and (h) ten for leisure/recreation.

Lastly, Table 4 provides an implementation timeline to serve as a guide for the occupational therapy practitioner to know when to administer specific assessments. Since an individual may experience change as a result of the passage of time, the table considers an individual's experience from three different points along his or her incarcerated journey: (a) custody, (b) at time of release, and (c) post release/community. It is recommended that eight of the assessments are administered during custody, five at time of release, and eight during the post-release/community timeframe. In addition, the table indicates whether or not the occupational therapy assessments would be valuable as a re-assessment tool. Eight of the occupational therapy assessments were identified as

being useful to re-administer, whereas only three assessments were specified as not providing valuable information upon re-administration.

Table 2: SAMHSA Guideline 2 OT Assessments in Relation to EHP
(SAMHSA, 2017)

For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on: (a) basic demographics and pathways to criminal involvement, (b) clinical needs, (c) strengths and protective factors, (d) social and community support needs, and (e) public safety risks and needs.

Occupational Therapy Assessment Tools	Assessing Person Factors (sensorimotor, cognitive, psychosocial skills, interests & values):	Assessing Context Factors (temporal, physical, social, or cultural):	Assessing Task Factors (observable behaviors that allow an individual to accomplish a goal):
<p><u>Volitional Questionnaire</u> (Gloria de las Heras, Geist, Kielhofner, & Li, 2007)</p> <ul style="list-style-type: none"> • Observational assessment used to examine how one's inner motives and environment affects their volition by seeing how they interact with the environment. • Can be used to evaluate clients regardless of abilities related to language or cognition. 	✓	✓	✓

<p><u>Assessment of Communication and Interaction Skills</u> (Forsyth, Salamy, Simon, & Kielhofner, 1998)</p> <ul style="list-style-type: none"> • An observation-based assessment used to evaluate communication and interaction skills encountered on a daily basis in meaningful activities. • Identifies client's strengths and weaknesses with regard to engagement in social participation in three domains: (a) physicality, (b) information exchange, and (c) relations. 	✓		✓
<p><u>Model of Human Occupation Screening Tool</u> (Parkinson, Forsyth, & Kielhofner, 2006)</p> <ul style="list-style-type: none"> • Assesses the client's occupational functioning by addressing: (a) volition, (b) habituation, (c) skills, and (d) environment. • The client is rated on a letter-rating scale called FAIR (F= facilitates occupational participation, A= allows occupational participation, I= inhibits occupational participation, R= restricts occupational participation). • Can be used to guide client goals and document progress. 	✓	✓	✓

<u>Occupational Performance History Interview-II</u> (Kielhofner et al., 2004) <ul style="list-style-type: none"> • Semi-structured interview that explores the client's occupational performance in the areas of work, play, and self-care. 	✓	✓	✓
<u>Role Checklist</u> (Oakley, Kielhofner, Barris, & Reichler, 1986) <ul style="list-style-type: none"> • A written inventory that is used to identify roles that are essential to the client's life. • Examines major roles that organize an individual's daily routine across the lifespan and identifies the perceived value of each role. • Roles considered include: (a) student, (b) worker, (c) volunteer, (d) care giver, (e) home maintainer, (f) friend, (g) family member, (h) religious participant, (i) hobbyist/amateur, and (j) participant in organizations. 	✓		
<u>Residential Environmental Impact Scale</u> (Fisher et al., 2014) <ul style="list-style-type: none"> • A semi-structured assessment that is used to examine the impact of community residential facilities on its residents. • Four areas are examined: (a) space, (b) 			

<ul style="list-style-type: none"> objects, (c) enabling relationships, and (d) structure of activities. Includes a walk-through of the home, observation of three daily routines or activities, an interview with the resident, and an interview with a caregiver. The purpose is to improve the residents' quality of life, focus on their sense of identity in terms of competence with occupational opportunities, and identify supports and barriers that affect engagement in meaningful occupations. 	✓	✓	✓
<p><u>Independent Living Scale</u> (Loeb, 1998)</p> <ul style="list-style-type: none"> The purpose is to examine the competency levels of adults performing IADLs. Comprised of five subscales, of which include: (a) memory/orientation, (b) managing money, (c) managing home and transportation, (d) health and safety, and (e) social adjustment. Evaluates the degree to which adults are capable of caring for themselves and their property based on performance. Results are beneficial in determining whether necessary support services, adaptations, or instructions to educate adults are needed to address areas of independent function. 	✓	✓	✓

<p><u>Allen Cognitive Level Screen</u> (Allen et al., 2007)</p> <ul style="list-style-type: none"> • A standardized assessment used to provide a quick estimate of a client's functional cognition, learning abilities, and problem-solving abilities by performing three visual-motor tasks of increasing complexity. 	✓		✓
<p><u>Adolescent/Adult Sensory Profile</u> (Brown & Dunn, 2002)</p> <ul style="list-style-type: none"> • Aids in the identification of sensory processing patterns and their effects on an individual's functional performance. • An individual's sensory processing is categorized into one of four quadrants: (a) low registration, (b) sensation seeking, (c) sensory sensitivity, and (d) sensation avoiding. • Understanding the complexities of sensory processing then allows for the design of strategies to help manage daily life and optimize desired sensory environment for the individual. 	✓		

<p><u>Occupational Questionnaire</u> (Smith, Kielhofner, & Watts, 1986)</p> <ul style="list-style-type: none"> • Documents the client's occupational participation in half-hour time segments for the duration of a day. • The client identifies his or her occupations as work, play, or leisure. • Then the client determines perceived level of competence in the occupation, the occupation's perceived value, and the perceived enjoyment gained from the occupation. 	✓	✓	
<p><u>Social Profile</u> (Donohue, 2013)</p> <ul style="list-style-type: none"> • A 40-item assessment divided into three topics: (a) activity participation, (b) social interaction, and (c) group membership/roles. • Measures social participation in group settings such as: (a) family, (b) schools, (c) clinics, (d) cultural groups, (e) clubs, (f) community groups, and (g) sports groups. • Five main levels of social functioning consist of: (a) parallel, (b) associative, (c) basic cooperative, (d) supportive cooperative, and (e) mature. • Can be used to evaluate groups or individuals. 	✓		✓

Table 3: SAMHSA Guideline 2 Criminogenic Risk Factors & OT Assessments
(SAMHSA, 2017)

For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on: (a) basic demographics and pathways to criminal involvement, (b) clinical needs, (c) strengths and protective factors, (d) social and community support needs, and (e) public safety risks and needs.

Criminogenic Risk Factors	Suitable Occupational Therapy Assessments
Criminal History	<ul style="list-style-type: none"> - Occupational Performance History Interview-II - Occupational Questionnaire
Pro-Criminal Companions	<ul style="list-style-type: none"> - Assessment of Communication and Interaction Skills - Occupational Performance History Interview-II - Role Checklist - Independence Living Scale - Social Profile
Anti-Social Personality Patterns	<ul style="list-style-type: none"> - Volitional Questionnaire - Assessment of Communication and Interaction Skills - Model of Human Occupation Screening Tool - Occupational Performance History Interview-II - Role Checklist - Residential Environmental Impact Scale - Independent Living Scale - Adolescent/Adult Sensory Profile - Social Profile
Pro-Criminal Attitudes & Cognitions	<ul style="list-style-type: none"> - Volitional Questionnaire - Model of Human Occupation Screening Tool - Independent Living Scale - Allen Cognitive Level Screen

Education/Employment	<ul style="list-style-type: none"> - Volitional Questionnaire - Assessment of Communication and Interaction Skills - Model of Human Occupation Screening Tool - Occupational Performance History Interview-II - Role Checklist - Independent Living Scale - Adolescent/Adult Sensory Profile - Occupational Questionnaire - Social Profile
Family/Marital	<ul style="list-style-type: none"> - Volitional Questionnaire - Assessment of Communication and Interaction Skills - Model of Human Occupation Screening Tool - Occupational Performance History Interview-II - Role Checklist - Residential Environmental Impact Scale - Independent Living Scale - Adolescent/Adult Sensory Profile - Occupational Questionnaire - Social Profile
Substance Abuse	<ul style="list-style-type: none"> - Volitional Questionnaire - Model of Human Occupation Screening Tool - Occupational Performance History Interview-II - Role Checklist - Adolescent/Adult Sensory Profile - Occupational Questionnaire
Leisure/Recreation	<ul style="list-style-type: none"> - Volitional Questionnaire - Assessment of Communication and Interaction Skills - Model of Human Occupation Screening Tool - Occupational Performance History Interview-II - Role Checklist - Residential Environmental Impact Scale

	<ul style="list-style-type: none"> - Independent Living Scale - Adolescent/Adult Sensory Profile - Occupational Questionnaire - Social Profile
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Table 4: SAMHSA Guideline 2 Implementation Timeline
(SAMHSA, 2017)

<i>For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on: (a) basic demographics and pathways to criminal involvement, (b) clinical needs, (c) strengths and protective factors, (d) social and community support needs, and (e) public safety risks and needs.</i>				
Occupational Therapy Assessment Tools	Custody	At Time of Release	Post-Release/Community	Valuable for re-assessment? (Y/N)
<u>Volitional Questionnaire</u> (Gloria de las Heras, Geist, Kielhofner, & Li, 2007)	✓	✓	✓	Y
<u>Assessment of Communication and Interaction Skills</u> (Forsyth, Salamy, Simon, & Kielhofner, 1998)	✓		✓	Y
<u>Model of Human Occupation Screening Tool</u> (Parkinson, Forsyth, & Kielhofner, 2006)	✓	✓	✓	Y
<u>Occupational Performance History Interview-II</u> (Kielhofner et al., 2004)	✓			N

<u>Role Checklist</u> (Oakley, Kielhofner, Barris, & Reichler, 1986)	✓		✓	Y
<u>Residential Environmental Impact Scale</u> (Fisher et al., 2014)		✓	✓	Y
<u>Independent Living Scale</u> (Loeb, 1998)		✓	✓	Y
<u>Allen Cognitive Level Screen</u> (Allen et al., 2007)		✓		N
<u>Adolescent/Adult Sensory Profile</u> (Brown & Dunn, 2002)	✓			N
<u>Occupational Questionnaire</u> (Smith, Kielhofner, & Watts, 1986)	✓		✓	Y
<u>Social Profile</u> (Donohue, 2013)	✓		✓	Y

Plan for the treatment and services required to address the individual's needs (while in custody and upon reentry)

Guideline 3

Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process. This consists of: (a) determining the appropriate level of treatment and intensity of supervision, (b) identifying and targeting multiple criminogenic needs, (c) addressing aspects of disorders that affect function, (d) developing strategies for integrating appropriate recovery support services, and (e) acknowledging dosage of treatment as an important factor in recidivism reduction (SAMHSA, 2017).

Throughout Guidelines 1 and 2, the occupational therapy practitioner is able to gather information on the person, context, and task performance to holistically understand areas of strengths and weaknesses of an individual with COD. Guideline 3 serves as a guide for various intervention ideas that an occupational therapy practitioner can incorporate to target the eight criminogenic risk factors using the EHP intervention approaches. Since criminal justice facilities have great variability in regard to rules and regulations, the interventions presented in Table 3 serve as suggestions that are to be chosen and interpreted using clinical judgment by the occupational therapy practitioner.

The EHP approaches consist of: (a) establish/restore, (b) alter, (c) adapt/modify, (d) prevent, and (e) create (Dunn, 2017). Establish/restore is an intervention approach used to either establish new skills, restore skills that are deficient, or restore skills that an individual has lost. Alter is an intervention approach that is focused on the context and requires that the occupational therapy practitioner match the person's current abilities with the best available context. The adapt/modify approach also focuses on the context, necessitating that the

occupational therapy practitioner change or adjust aspects of the context or task. The prevent intervention approach is aimed at taking action to avoid the development of future performance problems.

Whereas the aforementioned intervention approaches focus on a specific individual, the create intervention approach focuses on optimizing performance range for all populations and does not assume a performance problem exists (Dunn, 2017). In consideration of this manual, the create approach is not a direct intervention that would be implemented during treatment. Rather, the create interventions proposed in Table 5 serve as suggestions an occupational therapy practitioner can utilize to advocate for opportunities, expand existing community resources, and connect people to supportive social networks to optimize occupational participation for all.

The EHP-guided occupational therapy interventions are complementary to interventions provided by other professionals because they target: (a) level of functioning with regard to past experiences, (b) values and interests, and (c) psychosocial, cognitive, and sensorimotor factors (Dunn, 2017). Table 5 includes examples of such interventions that occupational therapy practitioners are equipped to implement with the population of people with COD. The interventions presented in Table 5 are categorized according to EHP intervention approaches and are classified as follows: (a) 20 establish/restore interventions, (b) four alter interventions, (c) six adapt/modify interventions, (d) seven prevent interventions, and (e) six create interventions. Evidently, the majority of interventions fall within the establish/restore intervention approach, which

primarily considers person factors. The remaining intervention approaches are largely concerned with the context and task factors.

Furthermore, Table 6 categorizes the EHP interventions presented in Table 5 by which would be most appropriate in targeting specific criminogenic risk factors. The number of EHP interventions recognized as appropriate for each criminogenic risk factor include: (a) 12 for criminal history, (b) eight for pro-criminal companions, (c) 15 for anti-social personality patterns, (d) 22 for pro-criminal attitudes and cognitions, (e) 16 for education/employment, (f) 14 for family/marital, (g) 21 for substance abuse, and (h) 13 for leisure/recreation. Since many interventions are versatile, multiple criminogenic risk factors may be addressed simultaneously.

Table 5: SAMHSA Guideline 3 EHP Intervention Outline
(SAMHSA, 2017)

<p><i>Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process. This consists of: (a) determining the appropriate level of treatment and intensity of supervision, (b) identifying and targeting multiple criminogenic needs, (c) addressing aspects of disorders that affect function, (d) developing strategies for integrating appropriate recovery support services, and (e) acknowledging dosage of treatment as an important factor in recidivism reduction.</i></p>	
EHP Intervention Approaches	Suitable Occupational Therapy Interventions
<p><i>Establish/Restore</i></p> <p>This intervention approach primarily focuses on “person factors and aims to improve the person’s skills” (Dunn, 2017, p. 216). An occupational therapy practitioner may help the client “establish” a new skill, or “restore” a skill that has been lost due to illness or injury (Dunn, 2017).</p>	<ul style="list-style-type: none"> • Leisure education/exploration (Ardovino, Fahey, Sprecher, & Froh, 2010) • Social skills training/social participation (Johnson et al., 2013) • Positive skills for romantic relationships/sexual health (Baker & McKay, 2001) • Assertiveness training (Baker & McKay, 2001) • Emotional regulation/coping skills (Barrenger, Draine, Angell, & Herman, 2017) • Anger management (Barrenger et al., 2017) • Money management (Crabtree, Ohm, Wall, & Ray, 2016) • Employment skills (Crabtree et al., 2016) • Communication/interpersonal skills (Crabtree et al., 2016) • Technology education (Crabtree et al., 2016) • Psychoeducation (Kendall, Redshaw, Ward, Wayland, & Sullivan, 2018) • Establish ability to self-reflect and develop insight into COD and limited performance range (Kendall et al., 2018; Lindstedt, Soderlund, Stalenheim, & Sjoden, 2004) • Daily/independent living skills (Sacks, Chapple, Sacks, McKendrick, & Cleland, 2012; van Vugt, Kroon, Delespaul, & Mulder, 2014) • Medication management (van Vugt et al., 2014)

	<ul style="list-style-type: none"> • Skills to fulfill role as family member/parent (Baker & McKay, 2001; Johnson et al., 2013) • Skills for formal education pursuits (Morgan, Fisher, Duan, Mandracchia, & Murray, 2010) • Time management skills (Lloyd, King, Lampe, & McDougall, 2001) • Decision making skills (Stahler et al., 2013) • Sensory diet/sensory integration • Skills to fulfill caretaker role (i.e. dog training program as a modality) (Britton & Button, 2005; Fournier, Geller, & Fortney, 2007)
<i>Alter</i>	<ul style="list-style-type: none"> • Alter social context to connect to positive, supportive social networks (Dunn, 2017) • Alter housing/neighborhood environment • Alter source of financial income if the previous source was illegal/maladaptive • Alter routines to avoid people, places, and things that are known triggers for substance use and criminal activity (Barrenger et al., 2017; Johnson et al., 2013; Kendall et al., 2018)
<i>Adapt/Modify</i>	<ul style="list-style-type: none"> • Adapt means of transportation • Simplify tasks for limited cognition • Modify medication management routines to ensure consistency • Modify response to environmental stressors • Adapt context to support/increase access to positive leisure pursuits (Farmworth, Nikitin, & Fossey, 2004) • Modify home environment to promote substance free lifestyle
<p>When utilizing the adapt/modify intervention approach, an occupational therapy practitioner would “change aspects of the context or make adjustments to task features” (Dunn, 2017, p. 216).</p>	

<p><i>Prevent</i></p> <p>The purpose of the prevent intervention approach is to “preclude the development of performance problems” (Dunn, 2017, p. 217). An occupational therapy practitioner may use this approach to reduce/prevent negative outcomes in person, context, or task variables.</p>	<ul style="list-style-type: none"> • Development of crisis prevention plans • Consult with prisons/jails to inform the institutions on the role of occupational therapy • Connect to community supports/resources upon release • Therapeutic community (Kerrison, 2018) • Orient individuals with COD to the realities of community living/expel unrealistic expectations (Johnson et al., 2013) • Substance use and mental health education • Provide opportunities for building work/volunteer experience (Barrenger et al., 2017)
<p><i>Create</i></p> <p>The create intervention approach does not assume that a problem exists, or that a problem will occur in the future. As such, this approach focuses on “creating circumstances that support optimal performance for all persons and populations” (Dunn, 2017, p. 217).</p>	<ul style="list-style-type: none"> • Community advocacy for affordable housing (Barrenger et al., 2017) • Consult community employers on behalf of workers with a variety of job skills/history • Opportunities for positive leisure participation within community (Farmworth et al., 2004) • Job skill workshops • Development of a health and wellness program • Mental health awareness workshop

Table 6: SAMHSA Guideline 3 Criminogenic Risk Factors & OT Interventions
(SAMHSA, 2017)

<i>Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process. This consists of: (a) determining the appropriate level of treatment and intensity of supervision, (b) identifying and targeting multiple criminogenic needs, (c) addressing aspects of disorders that affect function, (d) developing strategies for integrating appropriate recovery support services, and (e) acknowledging dosage of treatment as an important factor in recidivism reduction.</i>	
Criminogenic Risk Factors	EHP in Relation to Occupational Therapy Interventions
Criminal History	<p><u>Establish/Restore</u></p> <ul style="list-style-type: none"> • Psychoeducation • Establish ability to self-reflect in order to develop insight into COD and limited performance range • Medication management • Decision making skills <p><u>Alter</u></p> <ul style="list-style-type: none"> • Alter source of financial income if the previous source was illegal/maladaptive • Alter routines to avoid peoples, places, and things that are known triggers for substance use and criminal activity <p><u>Adapt/Modify</u></p> <ul style="list-style-type: none"> • Modify medication management routines to ensure consistency • Modify response to environmental stressors • Adapt context to support/increase access to positive leisure pursuits <p><u>Prevent</u></p> <ul style="list-style-type: none"> • Substance use and mental health education <p><u>Create</u></p>

	<ul style="list-style-type: none"> • Community advocacy for affordable housing • Development of a health and wellness program
Pro-Criminal Companions	<ul style="list-style-type: none"> • <u>Establish/Restore</u> • Social skills training/social participation • Communication/interpersonal skills • <u>Alter</u> • Alter social context to connect to positive, supportive social networks • Alter housing/neighborhood environment • Alter routines to avoid peoples, places, and things that are known triggers for substance use and criminal activity • <u>Adapt/Modify</u> • Modify response to environmental stressors • <u>Prevent</u> • Connect to community supports/resources upon release
Anti-Social Personality Patterns	<ul style="list-style-type: none"> • <u>Establish/Restore</u> • Social skills training/social participation • Assertiveness training • Emotional regulation/coping skills • Anger management • Employment skills • Communication/interpersonal skills • Psychoeducation • Establish ability to self-reflect in order to develop insight into COD and limited performance range • Skills to fulfill caretaker role (i.e. dog training program as a modality) • <u>Alter</u> • Alter social context to connect to positive, supportive social networks

	<ul style="list-style-type: none"> • Alter housing/neighborhood environment <p><u>Adapt/Modify</u></p> <ul style="list-style-type: none"> • Modify response to environmental stressors <p><u>Prevent</u></p> <ul style="list-style-type: none"> • Connect to community supports/resources upon release • Substance use and mental health education <p><u>Create</u></p> <ul style="list-style-type: none"> • Mental health awareness workshop
Pro-Criminal Attitudes & Cognitions	<p><u>Establish/Restore</u></p> <ul style="list-style-type: none"> • Assertiveness training • Emotional regulation/coping skills • Anger management • Money management • Psychoeducation • Establish ability to self-reflect in order to develop insight into COD and limited performance range • Medication management • Time management skills • Decision making skills • Skills to fulfill caretaker role (i.e. dog training program as a modality) <p><u>Alter</u></p> <ul style="list-style-type: none"> • Alter social context to connect to positive, supportive social networks • Alter housing/neighborhood environment • Alter routines to avoid peoples, places, and things that are known triggers for substance use and criminal activity <p><u>Adapt/Modify</u></p> <ul style="list-style-type: none"> • Simplify tasks for limited cognition

	<ul style="list-style-type: none"> • Modify medication management routines to ensure consistency • Modify response to environmental stressors • Modify home environment to promote substance free lifestyle <p><u>Prevent</u></p> <ul style="list-style-type: none"> • Development of crisis prevention plans • Connect to community supports/resources upon release • Substance use and mental health education <p><u>Create</u></p> <ul style="list-style-type: none"> • Community advocacy for affordable housing • Mental health awareness workshop
Education/Employment	<p><u>Establish/Restore</u></p> <ul style="list-style-type: none"> • Money management • Employment skills • Technology education • Daily/independent living skills • Skills for formal educational pursuits • Time management skills <p><u>Alter</u></p> <ul style="list-style-type: none"> • Alter source of financial income if the previous source was illegal/maladaptive <p><u>Adapt/Modify</u></p> <ul style="list-style-type: none"> • Adapt means of transportation • Simplify tasks for limited cognition • Modify response to environmental stressors <p><u>Prevent</u></p> <ul style="list-style-type: none"> • Connect to community supports/resources upon release • Orient individuals with COD to the realities of community living/expel unrealistic expectations

	<ul style="list-style-type: none"> • Provide opportunities for building work/volunteer experience <u>Create</u> <ul style="list-style-type: none"> • Community advocacy for affordable housing • Consult community employers on behalf of workers with a variety of job skills/history • Job skill workshops
Family/Marital	<u>Establish/Restore</u> <ul style="list-style-type: none"> • Positive skills for romantic relationships/sexual health • Emotional regulation/coping skills • Money management • Communication/interpersonal skills • Daily/independent living skills • Skills to fulfill role as family member/parent • Skills to fulfill caretaker role (i.e. dog training program as a modality) <u>Alter</u> <ul style="list-style-type: none"> • Alter social context to connect to positive, supportive social networks • Alter housing/neighborhood environment • Alter source of financial income if the previous source was illegal/maladaptive • Alter routines to avoid peoples, places, and things that are known triggers for substance use and criminal activity <u>Adapt/Modify</u> <ul style="list-style-type: none"> • Modify response to environmental stressors • Modify home environment to promote substance free lifestyle <u>Prevent</u> <ul style="list-style-type: none"> • Orient individuals with COD to the realities of community living/expel unrealistic expectations

Substance Abuse	<p><u>Establish/Restore</u></p> <ul style="list-style-type: none"> • Emotional regulation/coping skills • Anger management • Psychoeducation • Establish ability to self-reflect in order to develop insight into COD and limited performance range • Medication management • Decision making skills • Sensory diet/sensory integration <p><u>Alter</u></p> <ul style="list-style-type: none"> • Alter social context to connect to positive, supportive social networks • Alter housing/neighborhood environment • Alter source of financial income if the previous source was illegal/maladaptive • Alter routines to avoid peoples, places, and things that are known triggers for substance use and criminal activity <p><u>Adapt/Modify</u></p> <ul style="list-style-type: none"> • Modify medication management routines to ensure consistency • Modify response to environmental stressors • Modify home environment to promote substance free lifestyle <p><u>Prevent</u></p> <ul style="list-style-type: none"> • Development of crisis prevention plans • Connect to community supports/resources upon release • Orient individuals with COD to the realities of community living/expel unrealistic expectations • Substance use and mental health education <p><u>Create</u></p> <ul style="list-style-type: none"> • Community advocacy for affordable housing
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	<ul style="list-style-type: none"> • Opportunities for positive leisure participation within community • Mental health awareness workshop
Leisure/Recreation	<p><u>Establish/Restore</u></p> <ul style="list-style-type: none"> • Leisure education/exploration • Technology education • Time management skills • Decision making skills <p><u>Alter</u></p> <ul style="list-style-type: none"> • Alter social context to connect to positive, supportive social networks • Alter housing/neighborhood environment • Alter routines to avoid peoples, places, and things that are known triggers for substance use and criminal activity <p><u>Adapt/Modify</u></p> <ul style="list-style-type: none"> • Adapt context to support /increase access to positive leisure pursuits <p><u>Prevent</u></p> <ul style="list-style-type: none"> • Connect to community supports/resources upon release • Orient individuals with COD to the realities of community living/expel unrealistic expectations <p><u>Create</u></p> <ul style="list-style-type: none"> • Opportunities for positive leisure participation within community • Development of a health and wellness program

Guideline 4

Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment (SAMHSA, 2017).

Upon reentry to the community, individuals with COD often experience a disruption in the care they have been receiving while incarcerated, as contact with community mental health and substance use care is rare in the months post-release (Hamilton & Belenko, 2015). Even those that do access services commonly do not receive the appropriate level of care necessary to address the complexities of their comorbid conditions. Therefore, individuals with COD are at a heightened risk of: (a) facing poor health outcomes, (b) returning to drug abuse and criminal activity, or (c) experiencing an exacerbation of mental health symptoms (Binswanger et al., 2012). A formalized process of service continuity that emphasizes interdisciplinary collaboration is an imperative component of facilitating a smooth transition to the community, which can consequently lead to reduced recidivism rates (SAMHSA, 2017).

In anticipation of reintegrating into the community, Guideline 4 seeks to improve the continuity of care to ensure comprehensive treatment planning meets an individual's health needs and his or her risk level. Based on information gathered from the screenings, assessments, and intervention sessions, occupational therapy practitioners are equipped to analyze and interpret the criminogenic risk factor data from a functional perspective to determine the

behavioral health needs of an individual with COD. From this information, the occupational therapy practitioner can then identify if the individual is considered high risk (six or more criminogenic risk factors), medium risk (three to five criminogenic risk factors), or low risk (one to two criminogenic risk factors).

Figure 1 is a visual representation adapted from the Ohio Risk Assessment System: Pretrial Assessment Tool (ORAS-PAT). The ORAS-PAT is a classification instrument created with the intention to improve communication across criminal justice agencies, evaluate the risk level of offenders, and subsequently provide the appropriate level of support with the hope to reduce recidivism rates (Latessa, Lemke, Makarios, Smith, & Lowenkamp, 2010). The authors of this manual utilized the ORAS-PAT to guide the development of Figure 1 to represent the role of occupational therapy in correlation with the SAMHSA (2017) implementation guidelines.

The figure provides a broad overview of the degree of support an individual would need based on the level of risk identified by the occupational therapy practitioner. In particular, it suggests the level of supervision an occupational therapy practitioner may need to provide during intervention and indicates the level of assistance that may be required to help an individual establish post-release supports. Generally, the more criminogenic risk factors identified, the greater the support an individual with COD will need throughout intervention. Figure 1 was designed to complement and be used in conjunction with the criminogenic risk factors identified throughout the screening and assessment process (Table 1, 2, and 3) to further inform intervention

implementation (Table 5 and 6). After having identified an individual's level of risk, occupational therapy practitioners can refer the individual to other interdisciplinary professions based on the determined area of need. The occupational therapy practitioner will also assume responsibility for disseminating and interpreting the occupational-based findings to the interdisciplinary providers, as it is crucial for the enhancement of the care team's understanding of the individual as an occupational being.

Figure 1: Risk Level Categories

High Risk	Medium Risk	Low Risk
<ul style="list-style-type: none"> - 6+ criminogenic risk factors identified. - 1-on-1 intervention with occupational therapy practitioner. - Provided with community resources, post-release supports are established with significant assistance from team members. 	<ul style="list-style-type: none"> - 3 – 5 criminogenic risk factors identified. - Group occupational therapy sessions. - 1-on-1 intervention with occupational therapy practitioner as needed. - Provided with community resources, individuals work collaboratively with team members to set up post-release supports. 	<ul style="list-style-type: none"> - 1 – 2 criminogenic risk factors identified. - Group occupational therapy sessions. - Occupational therapy practitioner assumes more of an indirect role, consulting and/or supervising individual's treatment as needed. - Provided with community resources, individuals are expected to set up post-release supports with guidance from team members as appropriate.

Identify required community and
correctional programs responsible
for post-release services

Guideline 5

Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with co-occurring mental and substance use disorders leaving correctional settings (SAMHSA, 2017).

In order to facilitate successful reentry into the community for persons with COD, it is necessary to conduct re-assessment in the time period prior to release from prison or jail. Occupational therapy practitioners can refer to Table 4 for assessments that would be useful in determining the individual's level of occupational functioning at time of release. Re-assessing the individual will help the occupational therapy practitioner understand the progress that the individual has made throughout their incarcerated experience, as well as aid in identifying areas of deficits that continue to exist. The areas recognized as deficits will further guide the treatment collaboration between the occupational therapy practitioner and the individual's care team. Additionally, if it is determined that community-based occupational therapy is appropriate for the individual, the re-assessment will provide valuable information that the community occupational therapy practitioner could build upon to improve continuity of care.

The occupational therapy assessment tools that would be pertinent to administer or re-administer at time of release include: (a) Volitional Questionnaire (Gloria de las Heras, Geist, Kielhofner, & Li, 2007), (b) Model of Human Occupation Screening Tool (Parkinson, Forsyth, & Kielhofner, 2006), (c) Residential Environmental Impact Scale (Fisher et al., 2014), (d) Independent

Living Scale (Loeb, 1998), and (e) Allen Cognitive Level Screen (Allen et al., 2007). These assessments will identify the individual's cognition, competency, and overall ability to engage in daily life occupations with regard to volition and the community environment. Re-administering these assessments during the pre-release time frame reflects the integral nature of context in assuring a successful transition back into the community is achieved.

In response to assessment results, intervention approaches that would be particularly effective to use at the time of release would mainly focus on alter, adapt/modify, and prevent approaches. The occupational therapy practitioner can refer to Table 5 for suitable EHP-reflected interventions that can be appropriately utilized in community settings. Such approaches are directly concerned with an individual's context, which would be beneficial for improving supports and reducing barriers, thereby increasing performance range.

Figure 1 can be employed to help the occupational therapy practitioner determine the level of direct support an individual may need in the immediate hours, days, and weeks following release. Depending on the individual's identified level of risk (as determined in Figure 1), he or she will be referred to the appropriate community resources, including: (a) supported housing, (b) supported employment, (c) community mobility services, (d) mental health and/or substance use services, and (e) governmental entities that can provide access to basic needs (i.e. food, water, hygiene, clothing).

Guideline 6

Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages (i.e., warm hand-offs) for post-release treatment and supervision agencies (SAMHSA, 2017).

Ensuring continuity of care necessitates strong connections between the occupational therapy practitioner, the interdisciplinary care team within the jail or prison, and the care providers in the community at time of release. It is imperative that connections to the community providers and resources are made in a timely manner to reduce recidivism rates. Fostering relationships with community case managers, community resource caseworkers, mental health and/or substance use counselors, and community-based occupational therapy practitioners is an important role that the occupational therapy practitioner in the correctional facility must fulfill. Establishing connections and networks with other professionals requires that the occupational therapy practitioner maintains a client-centered approach in order to find service providers that will match the person with the level of support needed. Additionally, networking with other professionals helps connect the individual with beneficial services that can be utilized to attain community-based goals.

As determining policies and practices is a vital component of promoting continuity of care, the role of the occupational therapy practitioner is two-fold. During the time period prior to release, the procedure the occupational therapy practitioner will follow includes: (a) re-assessment (refer to Table 4), (b)

intervention recommendations that place an emphasis on context (refer to Table 5), and (c) community referrals. Based on re-assessment results, the data will further inform the occupational therapy practitioner's recommendations and referrals regarding the needs and criminogenic risk factors of the individual. Such considerations may reflect recommendations such as: (a) supported housing, (b) supported employment, and (c) community mobility and transportation. In following through with this procedure, the occupational therapy practitioner must clearly communicate with the interdisciplinary professionals and agencies to which the individual is being "handed-off." In doing so, the occupational therapy practitioner can guarantee that the various person, context, and task factors essential to increasing the performance range of an individual with COD is addressed and acknowledged.

Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

Guideline 7

Support adherence to treatment plans and supervision conditions through coordinated strategies (SAMHSA, 2017).

The purpose of providing treatment to an individual with COD while incarcerated is to expand his or her performance range in order to prepare for, and ease, the process of community reintegration. Facilitating a positive and supportive context improves adherence to treatment plans in the community for people with COD transitioning from prison, which will ultimately help reduce recidivism rates (Kendall, Redshaw, Ward, Wayland, & Sullivan, 2018). Based on the individual's determined risk level, the occupational therapy practitioner will have discussed methods to adapt/modify the task or context, worked in collaboration with the client to brainstorm ways to alter the context, and aided in the establishment of community supports and resources prior to release. To prevent the stagnation or diminution of performance range upon community reentry, it is essential that adherence to treatment plans and compliance to coordination strategies are established. The community occupational therapy practitioner, or other identified post-release supports, will continue to expound upon contextual interventions that could not be directly implemented while the individual was incarcerated.

Guideline 8

Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals (SAMHSA, 2017).

In order to progress the care team's goals for the individual with COD, the correctional institution must develop mechanisms to disseminate information from assessments and treatments across the interdisciplinary team to other providers. Since the mechanisms implemented by each institution will differ, it is critical that the occupational therapy practitioner determines how occupational therapy information can be easily accessed in a way that complements the institution's individualized system. Occupational therapy will contribute to the pre-existing mechanisms by sharing knowledge and information gathered about the person through occupational therapy-specific assessments and interventions. In addition, the occupational therapy practitioner will facilitate the sharing of knowledge by relaying the individual's risk level to interdisciplinary team members to assure areas of concern are being optimally addressed across disciplines and in the community. To contribute to the interdisciplinary conversation within an institution, Table 6 can be utilized by the occupational therapy practitioner to suggest interventions that target specific criminogenic risk factors experienced by individual's with COD to advance cross-system goals.

Guideline 9

Encourage and support cross training to facilitate collaboration between workforces and agencies working with people with co-occurring mental and substance use disorders who are involved in the criminal justice system (SAMHSA, 2017).

Cross training, which is known as the practice of being trained across multiple disciplines, is beneficial for achieving outcomes across institutions, in the community, and during the transition from prison or jail to the community (SAMHSA, 2017). The use of cross training results in a wealth of knowledge from multiple disciplines that encourages an interdisciplinary-friendly language and a shared goal-oriented mindset. Cross training allows for the streamlining of information regarding the individual's plan of care, informs professionals of criminogenic risk factors, and provides occupation-based assessment data, thus reducing misunderstanding and discontinuity in care. Occupational therapy practitioners should encourage and support the use of cross training by continually communicating with other professionals, using terminology that is easily understood, and promoting opportunities for other disciplines to collaborate and share knowledge.

Practical ways an occupational therapy practitioner can facilitate the streamlining of information across multiple disciplines include: (a) holding regular meetings regarding the individual's progress and intervention plans, (b) having an open line of communication with community resources and agencies, (c) allowing other professionals to have access to occupational therapy assessment data (when it is appropriate and in compliance with the individual's right to confidentiality), and (d) consulting with and

training professionals or case aides in the community who provide support to the individual. In conjunction with sharing the occupational therapy assessment data, it is necessary to ensure a holistic view of the person is evident throughout the cross training process by relaying information about the manifestation of mental illness and substance use, and how COD impacts one's occupational engagement.

Guideline 10

Collect and analyze data to evaluate program performance, identify gaps in performance and plan for long-term sustainability (SAMHSA, 2017).

To improve the delivery of occupational therapy services and ensure the viability of occupational therapy in the realm of criminal justice, evaluation measures must be established to identify areas that need improvement and recognize practices that positively influence community reintegration. In correctional facilities, occupational therapy practitioners must initially gather baseline data about individuals' functional capacities through the use of the assessment tools in Table 2. This baseline data will be compared and contrasted to the data obtained from re-assessment prior to release (refer to Table 4 for the implementation timeline of assessments). Occupational therapy practitioners can strategically use the information to identify whether the individual's performance range has expanded during incarceration with intervention, or if the individual's performance range has remained stagnant or decreased.

The *Occupational Therapy Practice Framework: Domain and Process*, 3rd ed., (OTA, 2014) identifies outcomes that are based on the experience of the individual, which can also serve as a means to evaluate program performance. Quality of life, improvement and enhancement of occupational performance, participation in desired occupations, role competency, well-being, and occupational justice are subjective outcome measures that can be valuable in assessing an individual's perception of his or her progress towards a desired performance range. The correctional institution is encouraged to explore and select from these suggested outcomes and utilize them as a

standard during periodic reviews. Evaluation of outcomes should occur throughout the individual's incarceration, prior to release, and shortly upon reentry into the community to aid in the identification of personal areas in need of improvement.

A Strength, Weakness, Opportunity, Threat (SWOT) analysis is a strategic planning process that evaluates the internal and external environment of an organization or program (Strickland, 2011). SWOT concepts are defined as follows: (a) positive aspects that are internal to the program (strengths), (b) negative aspects that are internal to the program (weaknesses), (c) positive aspects that are external to the program (opportunities), and (d) negative aspects that are external to the program (threats) (Strickland, 2011). This analysis process imparts information that could contribute to the growth and development of the use and implementation of this manual in a criminal justice setting. With the information attained from the SWOT analysis, occupational therapy practitioners are equipped to target areas of the proposed manual that may require further development or recognize areas of the individual's functioning that may necessitate further intervention. Furthermore, occupational therapy practitioners should incorporate the stakeholders' perspective of the reintegration program when completing the SWOT analysis to ensure overall satisfaction and sustainability of the program.

Case Study: An Example for Implementation

Daniel is a 28-year old Caucasian male from a small town in North Dakota who graduated with a bachelor's degree in business. While in college, Daniel rarely drank and he never experimented with drugs. He met his girlfriend, Cindy, in college. The two got along well, sharing interests in hunting, fishing, and hiking. After graduation, the couple moved in together. Shortly after settling into their new home, Cindy found out she was pregnant. The couple was elated and had support from both their families in raising their first child. Cindy planned to stay at home to raise the child while Daniel continued to work during the day at an accounting firm. Right before their child was born, Daniel's mother died unexpectedly. In dealing with the unfortunate loss of this mother, Daniel entered a depressive state. Upon the birth of his baby, Daniel continued to show signs of depression and started to withdraw from his parenting role, causing heightened tension in his relationship with Cindy.

On a particularly difficult night, Daniel had a friend offer him cocaine and he decided to try it. After a while, Daniel started using cocaine frequently and then progressed to experimenting with other drugs, such as heroin and meth. Cindy was made aware of Daniel's drug use problem when he had been fired from his job for inability to pass a random drug test. With Cindy being a stay-at-home mom and Daniel being unemployed, the couple struggled to make ends meet. The increased burden of financial stress caused Daniel's drug use to spiral out of control to the point in which he was using meth and other substances nearly daily. Daniel lost all of his friendships and became estranged from his family due to problems with drug use and behaviors resulting from his

depression and isolation tendencies. The escalation of his drug use also led to his separation from Cindy. With no place to turn, Daniel ended up living in the basement of his drug dealer's home.

Recently, Daniel was found to be in possession of meth during a routine traffic stop. He was adjudicated as guilty in a North Dakota court of law for a Class C felony drug possession charge and was served a 5-year sentence at the North Dakota State Penitentiary (NDSP). Upon incarceration, Daniel was found to meet the criteria for having substance use disorder as well as major depression. As part of the interdisciplinary treatment focus at NDSP, Daniel was assigned an occupational therapy practitioner to work with during his incarceration.

Case Study Application Questions

After critically analyzing the following questions, refer to the Appendix for potential responses.

1. Which multidisciplinary screening tools would be appropriate to administer upon initial evaluation with Daniel? (Guideline 1)
2. Which occupational therapy assessments could the occupational therapy practitioner use to supplement Daniel's assessment data? (Guideline 2)
3. Which criminogenic risk factors does Daniel present with? (Guidelines 1, 2, 3)
4. Which EHP intervention approaches would be most useful in addressing Daniel's person, context, and task factors? (Guideline 3)
5. Based on the criminogenic risk factors identified, what level of risk would Daniel be categorized as (high, medium, low)? (Guideline 4)
6. From the preliminary information provided above, what are the primary areas of occupation that may need to be addressed? (Guidelines, 1, 2, 3, 4)
7. What are some person factors that are potential barriers to Daniel's treatment? Potential supports? (Guidelines 1, 2, 3, 4, 5, 6, 7, 8, 9, 10)
8. What are some contextual factors that are potential barriers to Daniel's treatment? Potential supports? (Guidelines 1, 2, 3, 4, 5, 6, 7, 8, 9, 10)
9. What are some task factors that are potential barriers to Daniel's treatment? Potential supports? (Guidelines 1, 2, 3, 4, 5, 6, 7, 8, 9, 10)
10. What are some important considerations to ensure Daniel has a successful community reentry? (Guidelines 4, 5, 6, 7, 8, 9, 10)

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Appendix

Case Study Application Question Responses

While the occupational therapy practitioner should use clinical judgment to determine the intervention process for an individual with COD, the following are considerations in Daniel's case.

1. The following screening tools would be useful to supplement the multidisciplinary team's assessment data:
 - Behavior and Symptom Identification Scale – to screen for functioning in his interpersonal relations, self-understanding, role functioning, daily living scales, substance use, impulsivity, mood disturbances, anxiety, suicidality, and psychosis
 - Beck Depression Inventory II – to measure the intensity of his depressive symptoms and suicidality
 - Simple Screening Instrument for Substance Use – to examine Daniel's alcohol and drug use in the past 6 months, preoccupation and loss of control, adverse consequences, problem recognition, tolerance, and withdrawal
 - Beck Scale for Suicidal Ideation – to assess the presence, frequency, and severity of thoughts, plans, and intent to commit suicide; explore Daniel's openness about sharing suicidal thoughts to others and desire to live
 - Life Stressor Checklist – to assess stressful life events, such as his exposure to: traumatic events, natural disasters, accidents, physical/sexual abuse, divorce, foster care, and financial difficulties
 - Trauma Symptom Inventory – to evaluate the presence of acute and chronic trauma and examine the affective, cognitive, and physical issues related to trauma
 - Texas Christian University Motivation Form – to assess readiness for change, readiness for treatment, motivation, problem recognition, desire for help, pressures for treatment, and treatment needs
 - Level of Service Inventory Revised – to address psychosocial problem areas in his life, forecast criminogenic risk, aid in allocation of resources, and foster decision-making with regard to his future community placement
2. The following occupational therapy assessment tools would be potentially useful to administer upon initial evaluation with Daniel:
 - Volitional Questionnaire – to assess how Daniel's volition and environment impact his ability to interact in his context
 - Assessment of Communication and Interaction Skills – to see his strengths and weaknesses with regard to engagement in social participation
 - Model of Human Occupation Screening Tool – to assess how his volition, habituation, skills, and environment affect occupational performance
 - Occupational Performance History Interview II – to explore the history of Daniel's occupational performance in areas of work, self-care, and play
 - Role Checklist – to identify meaningful life roles across the lifespan and identify his perceived importance of each role

- Independent Living Scale – to assess how he performs in instrumental activities of daily living (memory/orientation, money management, home management and transportation, health and safety, social adjustment)
 - Allen Cognitive Level Screen – to provide information about his functional cognition, learning abilities, and problem-solving skills
 - Adolescent/Adult Sensory Profile – to understand his sensory processing patterns and how it affects functional performance in occupation
 - Occupational Questionnaire – to explore his occupational participation, perceived level of competence, and his perceived enjoyment and value in areas of work, play, and leisure
 - Social Profile – to measure his social participation in multiple group settings
3. Daniel presents with the following risk factors:
- Pro-criminal companions (drug dealer is his roommate)
 - Anti-social personality patterns (tendency to isolate and has lost friends by doing drugs)
 - Education/employment (fired from many jobs, recently unemployed)
 - Family/marital (struggles to fulfill role of father, estranged from family, separation from Cindy)
 - Substance abuse (meth and other substances)
 - Leisure/recreation (mainly occupies time with substance use)
4. The EHP interventions that would be most useful to address Daniel's person, contextual, and task factors are:
- Establish/Restore*
- Leisure education/exploration
 - Social skills training/social participation
 - Positive skills for romantic relationships
 - Assertiveness training
 - Emotional regulation/coping skills
 - Money management
 - Employment skills
 - Communication/interpersonal skills
 - Psychoeducation
 - Establish ability to self-reflect in order to develop insight into COD and limited performance range
 - Daily/independent living skills
 - Medication management
 - Skills to fulfill role as family member/parent
 - Decision making skills
- Alter*
- Alter social context to connect to positive, supportive social networks
 - Alter living situation (i.e. move out of drug dealer's basement)
 - Alter routines to avoid people, place, and things that are known triggers for substance use (i.e. friends that use substances, places he commonly would engage in drug activity)

Adapt/Modify

- Modify medication management routines to ensure consistency
- Modify response to environmental stressors
- Adapt context to support/increase access to positive leisure pursuits
- Modify home environment to promote substance free lifestyle

Prevent

- Development of crisis prevention plan (i.e. what to do if Daniel is offered a substance upon release)
- Connect to community supports/resources upon release (i.e. Narcotics Anonymous, housing developments)
- Orient Daniel to realities of community living post-incarceration/expel unrealistic expectations
- Substance use and mental health education

Create (for all populations)

- Create opportunities for positive leisure participation within community
- Community advocacy for affordable housing
- Mental health awareness workshop

5. Daniel presents with 6 criminogenic risk factors, thus categorizing him as medium risk.

6. Primary areas of occupation that need to be addressed with Daniel include:

- Social participation
- Instrumental activities of daily living
- Work
- Leisure

7. Potential barriers related to *person* factors include:

- Depressed
- Habitually uses substances
- Inability to deal with financial stress
- Lack of coping skills to deal with loss of mother
- Tendency to isolate
- Impulsive and willing to experiment with drugs at the risk of his health

Potential supports related to *person* factors include:

- College education
- Interested in hunting, fishing, and hiking
- May be motivated to fulfill role of father
- No other known health issues aside from the COD
- Limited ability to access drugs while in jail

8. Potential barriers related to *context* factors include:

- Living situation with drug dealer
- Social context is limited, estranged from family, friends, and significant other
- Unemployed
- Living in a small town in North Dakota may limit access to resources

- Loss of mother
- Daniel's age
- Jail context is limiting (physical, social, cultural)

Potential supports related to *context* factors include:

- Previously had a supportive family, friends, and significant other prior to becoming estranged
- Supportive employment history
- Daniel's history of drug use is not long-standing
- Caucasian male
- Will receive occupational therapy and interdisciplinary treatment while incarcerated (including medication)

9. Potential barriers related to *task* factors include:

- Prior to incarceration was unable to engage in everyday tasks without being under the influence of substances
- Inability to manage finances
- Social participation negatively impacted by substance use and depression
- Unable to access community housing options
- Occupational deprivation possible during incarceration

Potential supports related to *task* factors include:

- Able to perform tasks to fulfill an accounting job
- Previously able to fulfill tasks as a parent and significant other
- Positive leisure pursuits (hunting, fishing, hiking)

10. To ensure Daniel has a successful community reentry, it is important to consider the following:

- The level of support he will be receiving from family and friends post incarceration
- Ensure Daniel has access to mental health and substance use services after release
- Connected with a community occupational therapist, or an individual that is trained by an occupational therapist as a community support aid
- Establish working relationship with case manager
- Access to supported housing options
- Continues healthy medication management routine
- Access to resources that match Daniel with employment opportunities appropriate for his skill set
- Connect Daniel to healthy community/social supports that align with his personal interests (i.e. hunting, fishing, hiking groups/clubs)